

# Stakeholder Perspectives on Health Benefit Exchanges

**Cabinet for Health and  
Family Services  
Office of Health Policy**



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## Background

On September 30, 2010, Kentucky was awarded a \$1 million dollar State Planning and Establishment Grant for activities related to establishing an American Health Benefit Exchange ("Exchange") as required under Section 1311 of the Affordable Care Act (ACA). The new law which was enacted in March 2012, included numerous other provisions to expand coverage, provide more health care choices, enhance the quality of health care, increase accountability of insurance companies, and lower health care costs. The Exchange will serve to facilitate the purchase of qualified health plans, establish a Small Business Options Program ("SHOP Exchange") for employers in the small group market, and meet other requirements specified in the ACA.

The overall goal of an Exchange is to provide a one-stop-shopping experience for consumers using a "no wrong door" approach. The Exchange may be viewed as a mechanism for organizing the health insurance market allowing individuals and employers to compare plans in terms of price, benefits, services and quality. Also, by grouping individuals together under a single risk pool, the Exchange will create an efficient tool for reducing transactions and administrative costs, while increasing transparency.

One of the key issues facing Kentucky at this particular time is whether the State should establish a state operated Exchange, develop a partnership with the Federal government in establishing an Exchange, or default to the federal government, which will operate a federally-facilitated Exchange for individuals in States without a state-operated Exchange. Kentucky is currently exploring the feasibility of all options and will ultimately determine which option best fits the Commonwealth. In making this determination, Kentucky will engage Stakeholders as it has in the past and move forward in this process.

## Stakeholder Input

As a requirement of the planning grant, the Commonwealth is required to solicit stakeholders input relative to carrying out the activities of an Exchange. On April 18, 2011 a letter was sent to 45 stakeholders defining a Health Benefit Exchange and identifying the state flexibility options for the planning and implementation of an Exchange. Key stakeholders included: representatives of insurance agents and brokers, businesses, consumer advocates, health insurers, healthcare professionals, and other interested parties. The purpose of the letter was to solicit written comments, issues, and concerns relating to the establishment of a Kentucky-specific Exchange, including eligibility, functions, insurer participation, market rules, qualified health plans, risk sharing, structure and governance, financing, and consumer outreach and education.

A total of 24 Stakeholders responded to the letter for a response rate of 53%. This document provides a summary of Stakeholder responses to each question as well as other comments or concerns regarding a Kentucky Exchange that were not addressed in the letter. Regarding the summary of Stakeholder responses to each question it is important to note that not all Stakeholders responded to each question or issue presented in the letter. Also included in this document, is a copy of the original letter that was

sent to Stakeholders (Attachment A), a complete list of Stakeholder respondents (Attachment B), and the unique responses of each Stakeholder (Attachment C).

### **Structure and Governance: Stakeholder Perspectives**

#### **1. Should Kentucky design and operate its own Exchange?**

*Most Stakeholders (15/18) commented that Kentucky should design and operate an Exchange so that it can be designed to meet the needs of all Kentuckians, be free from political influence, transparent, and governed by a board with extensive knowledge of the insurance market, and represent a variety of stakeholders.*

#### **2. Kentucky options for the structure of an Exchange or number of Exchanges operated in the state.**

*Although several Stakeholders commented that the state should consider a multi-state regional Exchange, the majority of Stakeholders (10/17) commented that based on the size of the Kentucky market, the state should operate one Exchange instead of developing a regional or multi-state Exchange; combine the individual and small group to increase the risk pool; and share administrative processes.*

### **Eligibility and Employers: Stakeholder Perspectives**

#### **1. Definition of “small employer” (50 or less or 100 or less employees).**

*Approximately half of the Stakeholders (8/18) indicated a preference for maintaining Kentucky’s current small group definition of 2-50.*

#### **2. Exchange participation for large employers beginning in 2017.**

*One half of the Stakeholders (7/14) commented that large employers should not be allowed to participate in the Exchange because they are known to be more sophisticated purchasers of coverage, with different needs and more available resource. However, others expressed a need for more participants to stabilize the market and that this expansion will encourage employers to abandon group coverage and result in more Kentuckians getting coverage in the individual market with potentially higher costs.*

#### **3. Should there be participation requirements for employer groups in an Exchange?**

*More than one half of the Stakeholders (8/11) commented that there should be some form of participation requirements for employer groups, such as minimum percentage of employees participating; minimum employer contributions; limited number of plans for employees to choose from; and ability of employees to select programs and carriers.*

#### **4. Exchange design features that are likely to be important for employer participation.**

*Although one Stakeholder commented that “flexibility” will be a key factor to employers’ participation in the Exchange,” others (10/11) identified important Exchange design features, including a Web portal that is intuitive and easy to navigate and understand; an online comparison tool to look at specific coverage options by price and quality ; a wide variety of choice among health plans; a plan design to maintain and ensure high participation levels; transparency in pricing and benefits; decreased premiums; a streamlined application for employer tax credits; best practices; and an Exchange that will absorb certain key administrative functions such as notices, reporting, filing and data/information sharing.*

**5. Considerations that are important in facilitating coordination between employers and Exchanges and key issues requiring collaboration**

*Eight Stakeholders commented that consideration should be given to easing administrative burdens on small business employers; assisting employer groups to access the Exchange functions and available tax credits; a virtual Exchange’ determining if the employee coverage is “unaffordable” and sending subsequent notices to employers; utilizing existing resources like agents inside and outside of the exchange; and, communication between employers and the Exchange.*

**6. Other interests important to employers with respect to participation in the Exchange**

*Although two Stakeholders offered no comment/position at this time, most other Stakeholders (11/14) commented that other employers’ interests include allowing current programs and resources that are successfully working in the state to continue at no additional costs; providing support for small employers to transition into the SHOP Exchange and absorb as many administrative costs as possible; expanding manufacturers access to information; avoiding adverse selection; and encouraging healthy behaviors and lifestyle modification to lower premiums .*

**7. Should Kentucky operate a “Basic Health Plan” for individuals between 133% and 200% of the federal poverty level and use 95% of the tax credits that would have been available to these individuals for Exchange coverage to operate the “Basic Health Plan?” If so, what types of benefits should be included in the Basic Health Plan?**

*Less than one half of the Stakeholders responding to this question (4/9) commented that Kentucky should have a “Basic Health Plan” that includes preventive screening and allows for incentives to individuals who demonstrate reductions in risk factors such as, weight loss and tobacco cessation. However, others commented on the potential unintended consequences of creating a basic health program; a basic health plan is not a popular option in the current market; and such limited coverage is undesirable and should not be offered for fear of state mandates on provider payment rates, Medicaid rates and provider participation.*

**8. A required function of an Exchange is to determine eligibility for Medicaid and premium subsidies. What issues need to be considered in establishing an Exchange that will determine eligibility for Medicaid and premium subsidies?**

*Most Stakeholders(6/8) identified issues relating to an Exchange's determining eligibility for Medicaid and premium subsidies to be considered, including the use of a simplified set of eligibility rules that drive the system design; a structure which allows easy consumer navigation; reducing administrative burdens with a standard template used to capture personal information with a pre-populating function for known information and the report of a change in information; and a prompt seamless experience that ensures continuity of care.*

**9. How should the Exchange create a seamless system for individuals who fall back and forth between "Medicaid" eligibility and "premium subsidy" eligibility due to changes in income?**

*Several Stakeholders (3/4) commented that a seamless system may be created for these individuals if the State considers a one year lock in for the initial plan choice, providers are allowed to participate in Medicaid and Exchange plans, and the Medicaid managed care plans also offer private coverage in the Exchange.*

**10. How should continuity of plan coverage and provider networks be maintained for those individuals who fall back and forth between "Medicaid" eligibility and "premium subsidy" eligibility?**

*Although comments were very limited, one Stakeholder commented that the continuity of plan coverage and provider networks may be maintained if one integrated system is used to determine eligibility for Medicaid, CHIP, and premium subsidies with each carrier providing Medicaid coverage and coverage in the Exchange. This would allow individuals who migrate between Medicaid eligibility and Exchange subsidy eligibility to elect to stay within the same network and same benefit structure.*

**Functions:**

**1. Beyond the specifically listed functions, are there additional functions that should be considered for an Exchange?**

*Although three Stakeholders (3/10) commented that an Exchange should focus on the list of functions specifically outlined by PPACA, other Stakeholders (7/10) identified additional functions that should be considered, including functions that help to create a positive consumer experience, such as streamlining eligibility and enrollment processes and providing effective plan comparison tools; retain authority to set commissions; provide consumer claims assistance channels; address the inefficiencies and problems that cost manufacturing in Kentucky and the United States billions of dollars a year; monitor the unintended consequences and make midcourse changes as needed; and bring the best plans and services to consumers with affordable premiums and health care costs.*

**2. Navigator programs are required under the new law. What issues should be considered in establishing a Navigator program?**

*Generally, Stakeholders (15) commented that Navigators should be agencies, groups, individuals, or organizations with detailed familiarity of the insurance industry; recruited from the communities they will serve; able to serve disadvantaged, hard-to-reach, culturally*

*or linguistically isolated populations; accountable to the state; “certified” and trained; impartial and free of any conflicts of interest; and supported by Exchange funds at no additional cost to participants.*

**3. What should the role of agents play in assisting individuals with coverage in the Exchange?**

*Most Stakeholders (14/15) commented that as experts in insurance, agents are very valuable and useful, and could play an important role in the Exchange, particularly as it relates to assisting small employers in the selection purchase of insurance. However, some expressed a need for agents serving in this role to be ethical, regulated, and free of any conflicts of interest, and that agents could act as Navigators if they enroll individuals or groups in the Exchange.*

**Health Plan Participation:**

**1. Health plans participating in an Exchange must meet specific federal requirements. Should additional requirements be applied?**

*More than one half of the Stakeholders (8/14) commented that health plans should not be required to comply with additional requirements to participate in the Exchange.*

**2. Should all health plans be required to participate in the Exchange or should health plans compete or bid to participate in an Exchange?**

*Most Stakeholders (10/16) commented that participation of health plans in the Exchange should not be required. Of the remaining Stakeholders, several commented that health plans should be required to participate and others commented in favor of competition and the bidding process.*

**3. Should the number of benefit plans offered in an Exchange be limited or unlimited?**

*Although two Stakeholders offered no comment at this time, most of the remaining Stakeholders (10/11) were evenly divided (5/11; 5/11) on whether health plans offered on the Exchange should be limited or not limited and one Stakeholder (1/11) commented that the number of plans should be unlimited with the option to establish limits, if necessary.*

**Market Rules:**

**1. Should the same requirements/rules in the areas of marketing and network adequacy etc, apply to plans sold inside and outside of an Exchange?**

*Most Stakeholders (11/15) commented that requirements and rules relating to marketing and network adequacy should apply to plans sold inside and outside the Exchange.*

**2. Should health plans be required to offer the same product plans inside and outside of an Exchange?**

*Although one Stakeholder offered no comment at this time, more than one half of the remaining Stakeholders (7/12) commented that health plans should not be required to offer the same product plans inside and outside of an Exchange.*

### **Risk Sharing:**

- 1. States are required to establish a reinsurance program for individual health plans sold inside and outside an Exchange between 2014 and 2016. The program is to be funded by fully-insured and self-insured plans. Identify what issues should be considered in establishing a temporary reinsurance program?**

*Although one Stakeholder commented that this is an issue for underwriters and actuaries, other Stakeholders(8) identified issues relating to temporary reinsurance, including the need for a program that appropriately identifies and captures all high risk individuals, seeks to align reinsurance payments with the underlying risk, and ensures that carriers continue to have incentives to control costs/ manage the quality of care for individuals; the relationship between the reinsurance program and risk adjustment programs/mechanisms already established; a plan for how a state will handle a situation in which the need for funds one year is greater than the amount available under the ACA; the minimum impact of risk sharing activities on consumers; agreement on medical conditions identified as high risk; use of consistent actuarial assumptions and wellness incentives; need for development of minimum thresholds/scheduled reimbursements amounts; and a process for providing fair financing for consumers with high health care needs.*

- 2. A risk adjustment mechanism is required to be established for health plans sold inside and outside an Exchange to adjust for unequal distribution of actuarial risk. What issues should be considered in establishing a risk adjustment mechanism?**

*Although two Stakeholders offered no comment at this time, most other Stakeholders (6/7) identified issue relating to the risk adjustment mechanism, including conscientious enforcement of the mechanism ; the need for a standard federal (national) methodology to promote consistency across states and Exchanges, and minimize administrative burdens; agreement on how to determine initial risk score; and limits to prevent insurance companies from passing costs to consumers, including the young, healthy enrollees, through premium increases.*

- 3. For a health plan's business inside and outside an Exchange, PPACA establishes a single risk pool for small employer plans and a single risk pool for individual market plans as a way to mitigate adverse selection between an Exchange and the outside market. What issues should be considered regarding how risk pooling works between an Exchange and the outside market?**

*Seven Stakeholders identified issues that should be considered , including the unique administrative, service and insurance needs represented by the individual and small group markets that can only be accommodated through separate processes/ risk pools; allowing the subsidy to follow the individual which allows for the least amount of instability; no need for additional risk pooling if a carrier doing business in- and outside the Exchange uses the*

*same rates/rating structures for the same benefits; the need for risk pooling across plans with plans in each level; allowing employers to band together for cost containment/group purchasing; the need for the same rules (risk adjustment/ temporary insurance/risk corridor programs); and how risk pooling is critical to mitigate risk for adverse selection that would be present if carriers could develop different rates on and off the Exchange.*

- 4. States have been given the flexibility to merge the individual market and small employer group for rating and risk sharing. What issues should be considered regarding this option?**

*Although one Stakeholder had no comment at this time and two Stakeholders supported merging the two markets for rating and risk sharing, most Stakeholders (8/10) identified issues with and opposed merging the individual market and small employer group for rating and risk sharing, including the maintenance of separate risk pools to ensure carriers who choose to play in only one of two segments are not rewarded or penalized as a result; any dramatic market changes should be avoided at all costs; merging the two pools would be detrimental to the group market; combining the risk pools are likely to lead to higher rates for small groups due to adverse selection; costs may increase; separating the two markets will allow insurers to tailor benefit designs that best meet the needs of both individuals and small employers; and merging the two markets is likely to add an additional dimension of risk that carriers may not want or be able to assume .*

#### **Financing:**

- 1. A minimum essential benefit plan is required to be sold inside and outside an Exchange. A state may choose to require additional benefits but must cover the cost of the additional benefits for individuals eligible for premium subsidies through an Exchange. What issues should be considered regarding state requirements for additional benefits above the minimum essential benefit set?**

*Most Stakeholders (7/8) appeared to oppose the additional benefits and identified issues that should be considered, including the needs of the population; increased costs to programs or employers, and the State; the need for a wide range of choices for consumers; minimizing disruption as individuals who migrate between Medicaid eligibility and subsidized Exchange eligibility; and funding for extra benefits .*

- 2. What funding sources should be considered for the cost of additional benefits?**

*Although comments were limited to four, most Stakeholders (3/4) identified funding sources, including the state Medicaid funding pool, assessments on all insurers in the market and individuals purchasing the "richer" benefit plans.*

#### **Consumer Outreach and Education:**

- 1. What types of outreach strategies are likely to be most successful for an Exchange in enrolling individuals who are eligible for premium subsidies and cost-sharing reductions, and retaining these individual in an Exchange?**

*Ten Stakeholders identified numerous types of outreach strategies for successful enrollment and retention of individuals in an Exchange, including a broad-based outreach strategy like*

*duplicating the KCHIP outreach efforts; using agents/brokers and navigators; identifying individuals and providers for the purpose of providing workshops on basic health insurance ; providing a variety of information in a common language that is easily understood, presented in a simple standardized format, user friendly, and easy to compare; creation of a website for both health coverage and other public benefit program applications; following up when individuals drop out of the Exchange; and making information available in print and in person .*

**2. How can these outreach efforts be coordinated with efforts for other public programs?**

*Although one Stakeholder commented that the issues are still being considered, most Stakeholders (7/8) commented on how outreach efforts can be coordinated with efforts for other public programs by , partnering with licensed health care providers for distribution of standardized educational material to patients; communication with entities such as the NAIC (National Association of Insurance Commissioners) for the identification of specific disclosures/information and Diversity Councils for methods to reach individuals with diverse, cultural backgrounds; using various forms of communication and venues such as community centers, town hall meetings, churches and retail centers to distribute information; upon request, having an agent available to assist in selecting/servicing a health plan at no additional cost through the Exchange enrollment portal ; and using a model that draws upon online purchasing experiences of consumers, such as Travelocity, Amazon, eBay, and Craigslist.*

**3. What kinds of design features will help consumers obtain coverage through an Exchange?**

*Eight Stakeholders identified kinds of design features that will help consumers obtain coverage through an Exchange, including a website which presents information clearly, is designed for an individual to use without assistance, and allows the user to search by keyword, product, company, etc. The site should also offer cost and comparison tools and a toll-free hotline to receive “real time” assistance.*

**4. What information are consumers likely to find useful from Exchanges in making plan selections?**

*Although comments were limited, four Stakeholders identified information that consumers are likely to find useful in making selections in an Exchange, including information relating to plan choice such as benefits, ancillary products, chronic condition programs, wellness choices, provider networks, premium costs, and out of pocket cost sharing; Web-based tutorials for explaining how to use the site and compare/select plans; timely, reliable and comprehensive information, offered in a clear, concise format using simple, standardized terminology and descriptions; information on the Internet and in print; information relating to a health plan’s accreditation status, medical loss ratio, actuarial value, financials, paid/denied claims, handling/resolving complaints; information relating to management of common chronic conditions for both individual and small group markets.*

**5. Which types of enrollment venues are likely to be most helpful in facilitating individual enrollment in Exchanges and qualified health plans? No comments were received.**

6. What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plans to select? *No comments were received*
7. What are some best practices in conveying information to consumers relating to health insurance, plan comparison, and eligibility for premium subsidies, eligibility for Medicaid? *No comments were received.*
8. What types of efforts should be taken to reach individuals from diverse cultural origins and those with disabilities or low literacy? *No comments were received.*

#### **Additional Comments from Stakeholders**

**Other Comments:** *Please provide any other comments or concerns regarding a Kentucky Exchange that were not addressed.*

- Long-term economic sustainability of the Exchange should be carefully considered and operational expenses should be kept to a minimum to meet federal standards and avoid overreaching costs to states or other entities that might be asked to fund it. Due to current financial strains on physicians' offices to continue providing care to Kentuckians, it is the opinion of the KMA that they should not be asked to help fund the Exchange. (KMA)
- State exchange implementation should concentrate first on streamlining the administrative process for enrollment and eligibility by investing in the necessary IT and national infrastructure standards. These efforts should include reducing and monitoring fixed administrative expenses and working with the various stakeholders to eliminate unnecessary waste, costs or processing steps. We have concerns with unique state standards and rules which will make it difficult for health plans electing to participate in multiple state Exchanges across the country. (Humana)
- Based on the recent Kaiser Family report from March, 2011, which provided an extensive profile on the anticipated Exchange enrollee population, we encourage the state to focus their activities on addressing the needs of this unique population. It is critical that the Exchange program include innovative benefit design and various programs focused on disease management and helping members manage their chronic medical conditions. The intent of these programs would be to improve quality while controlling costs to ensure long term sustainability of this new purchasing arrangement.(Humana)
- We recommend that in addition to the use of structured annual open enrollment periods, that states consider additional mechanisms to reduce adverse selection within the new market dynamic. Exchanges should limit member requested plan changes mid-year to annually unless there is a qualifying event (i.e., birth, marriage, divorce, etc.). There should also be similar prohibitions or penalties for self-funded small employer arrangements which seek Exchange coverage mid-year. (Humana)
- Kentucky Physical Therapy Association (KPTA) does not have specific comments in answer to the questions posed in your April 18, 2011 letter requesting stakeholder feedback. However, KPTA would like to take this opportunity to provide some input into the implementation of the essential benefits package as outlined by the Patients Protection and Affordable Care Act (PPACA) and the role of physical therapists in the new Exchange as an essential benefit. With respect to the formulation of a state insurance Exchange in Kentucky, we suggest that any health insurance system or panel allow direct access to chiropractic providers without the necessity of a referral from another health care provider. (KPTA)
- PPACA specifies that a children's vision benefit be part of the essential benefit package. Children's coverage for comprehensive vision and eye health examination and materials is currently part of Medicaid and KCHIP. If a Basic Health Plan is created it should cover the diagnosis and treatment of

refractive and binocular disorders and eye health diseases and injuries of the eye, adnexa and visual system. Treatment should include but not be limited to surgery, medical means, corrective devices and/or other therapeutic procedures to maximize vision and eye health. To ensure network adequacy and timely delivery of needed services, any plan sold through the Exchange should require participation of optometrists and allow enrollees direct access to their local doctor of optometry. (KOA)

- Funding additional benefits is a societal decision and should be funded from the General Fund. Currently the Kentucky Access program is funded by Tobacco Settlement Funds a levy on small group and individual health insurance plans. ERISA plans, government and trade union programs pay nothing to support it. Small group employers are prohibited from sending individuals to the Kentucky Access program. As Kentucky Access is replaced by the new programs, this unfair taxation should be stripped. (National Federation of Independent Business/Kentucky)
- Benefit plans should emphasize wellness, disease prevention, health promotion and evidence based management of health solutions. Nurse practitioners should be recognized and reimbursed by all benefit plans as primary care providers who are eligible to establish health homes for their patients. In order to address the significantly increased demand for primary care services that will result from the implementation of the ACA, barriers to practice for nurse practitioners should be removed. (Dr. Beth Partin DNP, APRN)
- Our comments will mainly focus on the role of dental inside and outside Exchanges. (Delta Dental of Kentucky)
- A non-conflicted, diverse board of directors is essential for the Exchange. (Kentucky Equal Justice Center)
- Exchanges should also direct consumers to resources with information about how the health insurance system operates in Kentucky. Consumers need information about when, how and under what circumstances they can switch between plans, along with information on the transition of eligibility between Medicaid, KCHIP, and private coverage. Exchanges should alert consumers to the existence of and provide contact information for navigators, consumer assistance grant recipients, hospitals and pharmaceutical financial assistance programs, and other similar informational programs. (Kentucky Voices for Health)
- Open enrollment period rules that create an incentive for consumers to maintain continuous coverage will be critical elements in determining whether Exchanges attract a stable risk pool of members or suffer from severe adverse selection. Initial and ongoing enrollment periods should be structured to encourage consumers not to delay seeking coverage until the point where they will incur high out-of-pocket health care costs and then cease coverage immediately thereafter. A June 2010 study by Oliver Wyman on behalf of the Health Care Access Bureau of the Massachusetts Division of Insurance documented that the lack of a structured open enrollment period in the Massachusetts non-group market led to an increase in adverse selection that increased costs for the entire market. (United Healthcare)
- **Kentucky State Representative American Academy of Nurse Practitioners**

The current Kentucky Health System must be re-designed toward assisting Kentuckians in obtaining the appropriate care at the appropriate time in the appropriate setting. To support this goal, I submit the following recommendations.

- I. Create incentives that enhance utilization of Nurse Practitioners as primary care providers. There is a wealth of data and analyses regarding the cost-effective, quality care provided by Nurse Practitioners. We are all quite aware of the cost of inappropriate emergency department utilization.

- II.** Eliminate discriminatory business practices that block the Nurse Practitioner from performing to the full extent of her/his education, training and legal scope of practice,
- III.** Concerning payment systems, create methodologies for true transparency as to who is providing what care and at what cost, then directly tie incentives to those health care providers who demonstrate improved health outcomes for patients. All primary care providers should be held accountable for the quality and efficiency of care they provide as measured by patient outcomes.
- IV.** Greater utilization of Nurse Practitioners will aide the Commonwealth of Kentucky in health care delivery cost containment. In addition, Nurse Practitioners are experts in promoting preventative care and wellness programs and **support** patient shared decision malting thereby increasing patient satisfaction.
- V.** Support a system that maintains healthy competition in the health care marketplace and avoids oligopoly. In order for more selective and coordinated markets to be successful, employers as well as employees should, understand the value of receiving care from less-expensive, but equally qualified providers. They should also be educated to the long term consequences to their economic well-being if health **care** costs are not brought under control, Nurse Practitioners are a wise choice to promote in these policy changes and evidence of the **quality** of their practice is consistent with these objectives.

Thank you for your consideration of my comments. Nurse Practitioners are committed to using our skills to assist the Commonwealth of Kentucky in the realization of decreasing health care costs while assuring quality care for Kentuckians.

- **Kentucky Hospital Association: Other Issues Not Specifically Addressed in the Questions**

**Provider Networks — "Any Willing Provider"**

The statute sets out minimum criteria which must be met for a plan to be offered in the exchange. These criteria include ensuring a sufficient choice of providers, and including essential community providers within health insurance plan networks. KHA believes this is extremely important in order to provide consumers with an appropriate and broad choice of participating providers. In 1998, Kentucky enacted an "any willing provider" law which requires that any provider willing to accept the terms and conditions for participation must be included in a health plan's network. This legislation was enacted to assure that networks in Kentucky were adequate and to provide consumer choice. KHA believes it is extremely important that the any willing provider statute be applied to insurance plans sold both in and outside of the exchange in Kentucky, regardless of whether the exchange is operated by a state entity or the federal government. If this was not recognized by the exchange, it could result in a much narrower provider network and much less choice of providers for products sold through the exchange. The exchange should assure adequate choice of specialists and, as contemplated by law, must be prohibited from excluding providers who, based on their large amounts of uncompensated care, may have higher charges.

We also believe there should be criteria to evaluate the network adequacy of each plan. These criteria should be part of the quality rating system discussed below. Adequacy criteria could include an assessment of geographic availability to physicians and specialists and waiting time for consumers to receive services.

### **Provider Participation and Payment Rates**

The best way for exchanges to attract a wide number of participating providers and thus assure adequate networks is for participating health plans to pay reasonable reimbursement rates. If exchanges are structured and function to influence provider payment methods or lower payments below commercial rates, many providers will likely decline to participate in plans sold by the exchange. Such action would constitute indirect provider rate setting and is not appropriate for the exchange.

Additionally, to assure that providers are not unfairly pressured into participating in exchange plans with inadequate reimbursement rates, health care providers must be given the right to decide if they will participate in plans sold through the exchange separately from their decision to participate in a plan sold outside of the exchange. If providers are required, either by the state exchange or by a health plan, to participate in a plan sold through the exchange as a condition of their participation with an insurer's other products, providers will unfairly be "held hostage" to accept the rates that are set by the exchange or by the plan, as well as other terms and conditions which could be detrimental to their financial condition and long term viability. Under health care reform, Kentucky hospitals will experience Medicare reductions totaling \$3.4 billion (over ten years), new revenue from expanded coverage of an estimated \$2.1 billion, for a NET LOSS of \$1.2 billion. Kentucky's hospitals cannot afford to absorb additional payment cuts through Medicare or Medicaid-like rates which might be imposed through a state insurance exchange. For these reasons, providers must be given the right to negotiate their participation as well as the corresponding payment rates and other contractual terms and conditions separately from participation in plans sold outside the exchange.

### **Hospital-Based Physicians**

Hospitals and physicians must be permitted to independently decide whether they will participate in plans sold through the exchange. Hospitals cannot control and should not be expected to mandate that hospital-based physicians (who are not hospital employees) participate in exchange plans, even if the hospital chooses to do so. Otherwise, compensation for these physicians could be set at unreasonable rates by plans.

### **Quality Ratings**

The federal law requires the Secretary to develop a health plan rating system based on quality and price that would be used by the exchanges. KHA supports having uniform federal criteria for rating plans, as opposed to state specific criteria which would make it more difficult to compare plans. A rating system already exists for plans participating in the Medicare Advantage system. This is based largely on data from HEDIS measures, CAHPS measures, and the Health Outcomes Survey. This rating system has been criticized because the ratings do not show when a plan has improved, and all measures are rolled into one composite score which masks the specific areas in which a plan may be very good or very poor. KHA believes that the measures being used to develop the current rating system are appropriate for use to rate plans in the exchange; however, we believe that plans should be rated on individual measures rather than using an overall combined score. KHA is opposed to any interpretation of the law to extend the concept of health plan ratings to include individual provider ratings. Hospitals, specifically, already spend a considerable amount of resources reporting quality data to CMS. These measures are already publically available on the *hospitalcompare* website; therefore, there is no need to impose yet additional quality reporting through state exchanges on providers who are already participating in a national quality reporting program.

### **Silent PPOs**

Among the provider protections enacted in Kentucky is a prohibition on silent PPOs. It is important that a state exchange also prohibit the use of silent PPOs by health plans proposing to offer coverage in the exchange. Under such arrangements, a plan which does not have provider contracts, uses a third party administrator to "lease" a network from another PPO in which the provider participates, and applies that discount to their claims. Each health plan offering coverage in the exchange should not only be required to have an adequate Kentucky provider network, but should be required to negotiate rates with the providers listed as participating in their network.

### **Financing Operating Costs of the Exchange**

An important consideration in forming an Exchange is the funding source to maintain its operation after federal grant funding expires. Kentucky hospitals already pay a substantial provider tax to fund the Medicaid program and strongly oppose any increase in that tax as well as any new tax on hospitals to fund the exchange. KHA believes that the operational costs of the Exchange should be funded by a combination of fees on insurers, since they will benefit from additional customers enrolled by the exchange and reduced marketing/administrative costs, as well as on the employers and individuals purchasing coverage through the exchange. By keeping the functions of the exchange limited to operate like a clearinghouse, operational costs should be lowered and able to be covered through these means.

### **Standardization**

KHA believes that the Exchange should require standardization as much as possible among health plans so as to reduce administrative costs. This should include use of uniform claim forms, standardized electronic transactions, and use of standardized forms for pre-authorization, concurrent review, and claims attachments.

### **Compliance with State Laws**

KHA believes that all insurers selling products in the Exchange should specifically be required to comply with all state laws on patient protections (ie, network adequacy, coverage of emergency care, most favored nations), utilization review, internal and external appeal, prompt pay, use of uniform claim forms, and "any willing provider,"

- **America's Health Insurance Plans (AHIP)**

We are writing today on behalf of America's Health Insurance Plans (AHIP) and the Kentucky Association of Health Plans (KAHP) to offer comments in response to the Office of Health Policy's solicitation for comments regarding the implementation of a health insurance Exchange in Kentucky. AHIP is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. For nearly two decades KAHP has represented Kentucky plans on state legislative and regulatory issues. Our members offer a broad range of health insurance products in the commercial marketplace and have also demonstrated a strong commitment to participation in public programs.

Our industry has held a longstanding position in support of Exchanges as a vehicle to supplement existing avenues of purchasing coverage to provide consumers with access to innovative plan choices and clear and consistent information about their coverage options. Following the enactment of the federal Affordable Care Act (ACA), both the U.S. Department of Health and Human Services (HHS) and many states have begun the process of working through the various policy and design issues associated with the establishment of an Exchange. During this pivotal

time, our members stand ready to serve as a resource to help develop solutions that address structural, policy and technical challenges that will need to be navigated to ensure the development of workable structures.

States should use an open and transparent process to establish an Exchange that includes a diverse group of stakeholders. We therefore appreciate the opportunity to provide comments as an interested party and offer the following insights with respect to the issues raised in the comment solicitation on Exchange development.

### *Oversight*

Oversight and enforcement of Exchange-based insurance should be handled by existing state agencies, including the Kentucky Department of Insurance. These regulators currently evaluate compliance with state laws and have oversight of carrier licensure requirements including solvency, market conduct, products offered, rates, and network adequacy. They understand the best ways to avoid conflicting or duplicative regulations and enforcement responsibilities. Existing agency expertise processes, and structures will ensure greater administrative efficiency, coordination, and use of resources in the new Exchange.

### *Governance*

ACA requires the governance of an Exchange to be a governmental agency or nonprofit entity established by the state. In establishing the governance structure, Kentucky should strive to incorporate the following principles:

1. Broad stakeholder representation including representation from health plans including dental carriers, consumer representatives, and employers. There is significant value in seeking input on design issues and involving a wide spectrum of stakeholders in that process.
2. Transparent process for decision-making.
3. Financial and budgetary expertise to ensure that the Exchange operation maximizes efficiency and keeps administrative expenses low.
4. Accountability to state legislators or another appropriate body with respect to any funding assessments and taxes related to Exchanges to ensure the proper and efficient use of such funding for Exchange operations.
5. Ensuring a mission closely linked to the functions outlined in the statute such that regulatory functions performed by other regulatory bodies are not duplicated in order to ensure a better, high value experience for the consumer.

If the Exchange is established as an independent nonprofit entity, it should have accountability to the state Legislature with mandatory statutory reporting requirements that provide the Legislature with oversight of the funding and operations of the independent Exchange entity.

If Kentucky chooses to establish the Exchange as a governmental agency, the Exchange could be created as its own agency or housed within the Kentucky Department of Insurance or the Cabinet

for Health and Family Services. Creating an independent agency to administer the Exchange ensures that regulatory duties and operational considerations are clearly allocated.

The agency approach also provides the independence from existing regulators that is necessary to ensure that decision-making relating to the Exchange maintains the central focus of efficiently and effectively administering Exchange operations. In states creating an independent agency to administer the Exchange, careful consideration should be paid to avoiding duplication of regulatory and enforcement responsibilities already allocated to existing state agencies.

#### *Voluntary Exchange Participation*

A health plan should be able to participate in the Exchange if it meets the criteria for selection as a qualified health plan in the Exchange, and is licensed and in good standing in Kentucky. Any Exchange process should make the eligibility criteria for participation consistent and objective so individuals, working families, and small employers will have clear choices when it comes to the type of coverage available to them. We do not believe that it is in the best interest of consumers, who benefit from choice and competition, for either the state of Kentucky or HHS to establish a model that requires bidding by plans, a selective contracting process, or some other form of negotiation with carriers for participation.

#### *Coverage Outside the Exchange*

It is critical that the establishment of an Exchange does not eliminate the current health insurance marketplace or give an unfair competitive advantage to Exchange products over options made available outside the Exchange. For example, state imposed benefit mandates should not differ between products offered inside and outside the Exchange. That way, consumers have equal choices and are not directed into one market or the other based on their health status or needs.

Having a robust Exchange and outside health insurance market ensures choice and competition among health insurance options, which is critical to a well-functioning marketplace. We believe Exchanges should enhance, but not replace, existing markets to ensure that consumers can keep the coverage they currently have. Further, any initiative that forces all new coverage offered to individual market and small-group plans to be inside the Exchange will harm the existing market and potentially stifle innovation within the Exchange by placing too many barriers, restrictions, and regulatory mandates on plans.

#### *Plan Design*

It is very important that non-group and small-group plans sold outside the Exchange are not required to have identical benefit designs as plans within Exchange, but should follow the same market regulation standards. Both markets — inside and outside Exchanges — are subject to the same ACA market reforms of September 2010 such as continued coverage of young adults under their parents' policies, and grievances and appeal. Additionally, both markets are subject to the same ACA market reforms in January 2014, such as individual and small group adjusted community rating reforms and guaranteed issue with no pre-existing condition exclusions.

However, the types of qualified health plans and plan designs offered through Exchanges are not required outside the Exchange by the ACA. Not every carrier follows the model of coverage required by the Exchange (e.g., many plans currently sold in the individual market are without a

managed care component). Forcing the insurers to create new plans to meet these criteria to be able to remain in the state's insurance market could present a number of unintended consequences regarding the scope of coverage provided and the cost of plans available.

In addition, the Exchange should not attempt to establish quality improvement standards beyond those required under the ACA. This will add a new administrative level to costs and may cause the market to experience a loss of carriers due to over-regulation. We believe high quality health plans will continue to be offered regardless of whether the plan is sold inside or outside of the Exchange. In addition to the strong quality commitment plans have made to all their members, the ACA allows for and encourages quality requirements to be implemented by 2014 for plans offered inside and outside of an Exchange.

#### *Minimize Adverse Selection*

We recognize adverse selection is a risk management issue of concern, and agree Exchanges must be designed in a way so as to avoid adverse selection issues. Exchanges should incorporate the various tools available to ensure a fair and healthy risk pool. For example, several mechanisms for risk sharing are being developed at the federal level over the next several years including a temporary reinsurance program, risk corridors, and a risk adjuster mechanism. We encourage Kentucky to look to the forthcoming federal communication for guidance on this issue. Structured annual enrollment periods (operated both inside and outside Exchanges) should also be established so there are clear rules with respect to accessing coverage to help ensure that people purchase and maintain coverage, simplify the enrollment process, and help avoid potential cost implications created when consumers purchase coverage only when medical services are needed.

Further, for rating purposes, we believe the non-group and small-group markets should be kept as separate risk pools. Merging these markets is not a prudent step to ensure a smooth transition to the Exchange system, especially at the outset, due to the fact that the overall experience of the individual market, which is exposed to greater adverse risk selection and therefore costs, would cause small groups' rates to be higher in absorbing the higher risk individual population.

#### *Funding*

ACA provides that states will ultimately bear financial responsibility for non-federal Exchanges. Beginning on January 1, 2015, states must ensure that their Exchanges are self-sustaining and capable of generating revenue. Kentucky will need to consider several issues as they secure funding sources including considering the attribution of costs to various stakeholders including consumers.

The following principles should always be considered as a part of any legislative model that includes a funding provision:

- Any assessments or fees charged to carriers are limited to the minimum amount necessary to pay for the administrative costs and expenses incurred in the operation of the Exchange, after consideration of other available funding.
- Any assessments or fees charged to carriers should not include any amount based on HIPAA excepted benefit plans or premiums for HIPAA excepted benefit plans.

- Services performed by the Exchange on behalf of other state or federal programs shall not be funded with assessments or user fees collected from health insurers.
- Any unspent funding by an Exchange shall be used for future state operation of their Exchange or returned to health carriers as a credit if a state charges fees to carriers.

Taxes, fees or assessments used to finance the Exchange must be clearly disclosed by the Exchange as such, must be considered a state tax or assessment as defined in section 2718(a) of the PHSA and its implementing regulations, and therefore must be excluded from health plan administrative costs for the purpose of calculating medical loss ratios or rebates.

#### *Broker/Producer Commissions*

For Exchanges to be successful, they will need to be an attractive option to consumers and brokers/producers. Brokers/producers will be encouraged to work with Exchanges when they see a level playing field on compensation and opportunity. Compensation bias may occur if Exchanges begin setting limits on opportunities for producers. If the level of commissions on programs sold in Exchanges is too low compared to other markets or other lines of business, we would expect to see brokers/producers focus on the markets and programs outside of Exchanges. In addition, we support carriers retaining the ability to set broker commissions.

We appreciate you taking our views into consideration and would be happy to discuss our position and these concerns with you further.

- **Kentucky Association of Manufacturers (KAM)**

Although we have attempted to answer all of the questions posed in the solicitation letter, I wanted to further emphasize how important health insurance benefits are to Kentucky manufacturers. They are key to attracting the type of workforce necessary for Kentucky manufacturers to compete globally. However, the cost of those benefits are also a growing concern to manufacturers as they try to restrict overhead expenses to compete globally. As the Commonwealth looks to create a health benefit exchange, it is imperative that the state avoid duplicate and additional regulatory burdens, benefit mandates, and other policy decisions that will increase costs. Increased costs for these benefits are unsustainable and pose significant threats to Kentucky's economy.

- **Independent Insurance Agents of Kentucky (IIAK): Comments Regarding Consideration of a Health Benefit Exchange**

On behalf of the Independent Insurance Agents of Kentucky (IIAK), I write to offer our organization's response to your request for comments regarding the establishment of a Health Benefit Exchange in the Commonwealth pursuant to the federal Patient Protection and Affordable Care Act (PPACA or "the Act").

IIAK has significant interest in the development of the exchange, and we look forward to working with the Office of Health Policy and other state agencies on this and other PPACA implementation issues. Our association represents thousands of health insurance agents, advisors, consultants, and employee benefit specialists, and our members guide a diverse universe of consumers through the complexities of health insurance purchasing and

enrollment and help ensure buyers get the best policy at the most affordable price. These trained and licensed professionals help clients balance their desire for highly-quality and comprehensive coverage with the reality of rapidly escalating medical treatment costs. Perhaps most importantly, the work of our members continues throughout the life of each policy sold and typically includes providing guidance and assistance with claims issues, service questions, and quality enhancement and compliance matters.

## **Functions**

### *Functions Assigned by the Act*

Section 1311(d)(4) and other provisions of the Act assign certain responsibilities and duties to state exchanges, and these functions can and should be performed in a manner that is both efficient and consistent with the Act's goal of fostering competition. While certain of these tasks will be completed by the exchange directly, there will be other activities that will likely be performed by existing state agencies. Section 1311(f)(3) of Act also enables exchanges to contract with private sector entities, and the state should consider whether such entities can efficiently provide certain administrative- and technology-related functions that will be necessary for the operation of the exchange. It may be more cost-effective, in some instances, for private sector businesses to perform some of the non-essential work and provide the behind-the-scenes technological infrastructure needed by a functioning exchange.

### *Navigators*

Section 1311(i) of PPACA requires state exchanges to establish a Navigator program and to award grants to eligible entities that perform the duties identified in the Act, and IIAK has great interest in the manner in which this program will be structured. The Act requires Navigators to conduct administrative and marketing activities that are designed to promote the existence of the exchange to those who are likely to be qualified to enroll in a qualified health plan. As described by the National Association of Insurance Commissioners (NAIC) in its August 2010 resolution regarding the role of licensed insurance professionals, the purpose of Navigator programs is to "conduct public education and distribute fair and impartial information concerning enrollment in health plans and provide referrals for consumer assistance." While these are important activities, they are appropriately limited in nature and scope and should not be expanded in any respect.

The NAIC's recently adopted resolution also observes that Navigators will not be qualified or authorized to engage in all activities that are appropriate and permissible for fully licensed insurance producers, and it expresses concern that untrained individuals might seek to utilize the program to "evade producer licensing requirements and expose consumers to harm." IIAK shares these concerns. We believe that any person - regardless of their title, position, or status - who confers with or offers advice to consumers concerning the substantive terms of a health plan or competing plans or engages in actual enrollment activities must be licensed as an insurance producer. The producer licensing system has protected consumers for many years by ensuring that only competent and qualified professionals are authorized to sell, solicit, or negotiate insurance, and we believe these strong mandates must continue to apply to all exchange-related activities and enrollments.

It is critical that all applicants are properly vetted and scrutinized and that grants are provided judiciously and with proper ongoing oversight. Since the grants awarded by the Navigator program will be made from state - and not federal - dollars, it is also imperative that the program includes safeguards that ensure accountability and transparency and prevent fraud, waste, and abuse.

### ***Additional Functions***

PPACA imposes a lengthy series of mandates and responsibilities on state exchanges, and additional requirements may be established by the Department of Health and Human Services in the weeks and months to come. We do not see a need, at this time, for assigning responsibilities not contemplated by the Act to the exchange. Every state establishing an exchange will face considerable burdens and hurdles, and we do not believe it is prudent for Kentucky to tackle additional challenges at the outset.

### **Eligibility**

#### *Employer Eligibility*

IIAK believes Kentucky should utilize the discretion provided by Section 1304(b) (3) of the Act and limit group eligibility to employers with 50 or less employees during the exchange's first two years. Establishing an exchange and getting it operational will be a daunting and complex task for the state, and the effort will inevitably confront unanticipated challenges along the way. Expanding the eligibility threshold at the outset is likely to undermine the exchange's chances of success in its early years, and we instead urge you to begin with a more manageable level of participation the state to establish a structure and venue for regular dialogue with our association and other leaders in the producer community.

#### *Regional Exchanges*

PPACA permits states to join together to establish regional exchanges, but we are skeptical about the utility of such an approach. We fear regional exchanges would provide additional challenges and result in confusion among stakeholders, overlapping and conflicting state requirements, and cross-subsidization among jurisdictions. In short, our initial conclusion is that the disadvantages associated with regional exchanges appear to outweigh any advantages and benefits.

### **Financing**

#### *Funding Sources*

The Act requires state exchanges to become financially self-sufficient by 2015, and we urge Kentucky to consider and examine a wide range of possible funding sources (including those not targeted exclusively at the health insurance industry).

### ***Additional Required Benefits***

The Act provides states with the option of requiring health plans participating in the exchange to offer certain benefits that extend beyond the essential health benefits outlined in Section 1302; however, any state that imposes more stringent coverage requirements must cover the cost of these

additional benefits for individuals securing coverage through the exchange. Market disruption and unanticipated consequences could arise if additional benefit mandates are imposed only on plans operating outside the exchange, and we think it most appropriate to establish a level playing field with regard to benefit levels inside and outside the exchange.

### **Other Comments**

Perhaps the most notable concern of IIAK is ensuring that individuals and small groups examining their alternatives and securing coverage via the exchange have the ability to do so with the assistance and guidance of a licensed insurance producer. Thousands of licensed insurance professionals in this state have dedicated their careers to effectively serving the insurance needs of their customers, and they bring unmatched experience and expertise to their work. The Act recognizes the benefits provided to consumers by the agent community and permits producers to enroll individuals and small groups in plans offered through the exchange and help consumers apply for applicable tax subsidies. IIAK believes that any exchange established in Kentucky should enable producers to continue to provide these integral and valuable services and provide interested consumers with the capability to contact and work with a qualified agent. IIAK strongly concurs with the sentiments expressed by the NAIC's recently adopted resolution and agrees that employers and consumers will need the professional guidance provided by agents more than ever. The resolution accurately notes that insurance producers play an "indispensible role" in the health insurance arena, and it is essential that any new exchange environment provide agents with the opportunity to compete fairly, provide the level of service and responsiveness expected by clients, and be "adequately compensated for the services they provide." As you consider the establishment of the exchange, it is critically important to ensure that producers are appropriately and fairly compensated for the level of service they provide. Finally, it is vital that any person who sells insurance coverage, enrolls purchasers in plans, or confers with or offers advice to consumers about coverage options be required to comply with existing state licensing and marketplace requirements.

### **Conclusion**

On behalf of the countless independent insurance agents operating throughout Kentucky, we sincerely thank you for the opportunity to submit these comments. We are happy to assist your further consideration of the development of the exchange in any way you deem appropriate, and we would be pleased to participate in any subsequent discussions that occur concerning these issues.

- **Kentucky Medical Association**

This is in response to your letter concerning establishment of a Health Benefit Exchange in Kentucky as indicated by the passage of the Affordable Care Act (ACA). KMA appreciates the opportunity to provide input and, via this letter, we will present a broad overview of how the Association thinks the state-based exchange should function.

The Kentucky Medical Association urges the Commonwealth to establish a state-based exchange. The KMA also believes the exchange should function as an easily understood portal of information for consumers, health care providers, employers, insurers, and others. According to ACA, the Exchange should also qualify consumers for federal subsidies for the purchase of health insurance.

The information provided to consumers and others should be user-friendly to individuals using the Internet or who might call seeking assistance. It should also be transparent and easily understood by most any Kentuckian and provide a comparison tool that will allow citizens to determine the best insurance benefit plan that meets their budget and health care needs.

The oversight body of the Exchange should include consumer, physician, and other stakeholder representation. The leaders should also ensure that health plans selling insurance in Kentucky abide by the state's patient protection and provider fairness statutes and regulations. Health plans qualified by the Exchange to participate should be subject to reasonable and fair premium rate standards and ensure administrative simplification for physicians who choose to participate with the health plans qualified by the Exchange.

Long-term economic sustainability of the Exchange should be carefully considered and operational expenses should be kept to a minimum to meet federal standards and avoid overreaching costs to the state or other entities that might be asked to fund it. Due to current financial strains on physicians' offices to continue providing care to Kentuckians, it is the opinion of the KMA that they should not be asked to help fund the Exchange.

By following these general guidelines, an Exchange can be a beneficial tool for Kentuckians seeking insurance coverage in the individual and small group markets. Again, we appreciate the opportunity to comment. As the Cabinet continues to develop its thoughts about a state-based Exchange, KMA requests that you keep us apprised and provide the opportunity to comment. Participation of the state's physicians in planning for a state-based Exchange will be critical to its success.

## Attachment A

April 18, 2011

<<Name>>  
<<Address>>  
<<City, State, Zip Code>>

Dear <<Name>>

The Patient Protection and Affordable Care Act (PPACA), Public Law 111-148 enacted on March 23, 2010, and modified by the Health Care and Education Reconciliation Act, Public Law 111-152 enacted on March 30 2010, requires a Health Benefit Exchange (“Exchange”) to be operational in each state by January 1, 2014. In general, a Health Benefit Exchange is an organized, competitive marketplace to facilitate the comparison, choice, and purchase of health insurance coverage for individual consumers. Various sections of PPACA, establish requirements and options for states pertaining to:

- 1) the functions or responsibilities of an Exchange,
- 2) eligibility for participation in an Exchange and impact on Employers,
- 3) health plan participation in an Exchange,
- 4) market rules for benefit plans offered inside and outside an Exchange,
- 5) risk sharing arrangements to mitigate adverse risk selection among health plans participating inside and outside an Exchange,
- 6) the structure and governance of an Exchange,
- 7) the financing of Exchange operations; and
- 8) consumer outreach and education.

The Commonwealth of Kentucky was approved for a Health Benefit Exchange planning grant on September 30, 2010. As a requirement of the planning grant, the Commonwealth is required to solicit stakeholder input relative to carrying out the activities of an Exchange, and this letter is soliciting such input. This request identifies a broad set of areas of interest for a Health Benefit Exchange. Examples are provided to highlight the types of questions that are of interest; however, these examples should not be viewed as an exhaustive list of the only questions of interest. Commenter’s may respond to one or more of the following areas or questions, or

provide comment on Exchange issues or questions not listed. Please indicate the questions to which you are responding.

**Functions:**

1. An Exchange is responsible for performing a specified list of functions. Beyond the functions specifically listed, are there additional functions that should be considered for an Exchange?
2. A “Navigator” program is required to be established under an Exchange to conduct outreach and assist individuals and employers with enrollment. What issues should be considered in establishing a “Navigator” program?
3. Agents play an important role in assisting individuals and employers with purchasing health insurance coverage. What role should agents play in assisting individuals with coverage in the Exchange?

**Eligibility and Employers:**

1. Individuals and small employers are eligible to participate in an Exchange in 2014. Small employers may be defined as 50 or less or 100 or less employees. Which definition of small employer should be used for initial Exchange participation in 2014?
2. Exchange participation is allowed for large employers beginning in 2017. Should large employers (greater than 100 employees) be allowed to participate in an Exchange? Should there be an upper limit on large group participation in an Exchange (i.e. 200, 500, etc. employees)?
3. Should there be participation requirements for employer groups in an Exchange (i.e. minimum share of employees participating, minimum employer contribution, limits in the range of product benefit values that may be selected by employees – all employees must choose from one actuarial level, etc.)?
4. What Exchange design features are likely to be important for employer participation? What are some relevant best practices?
5. What considerations are important in facilitating coordination between employers and Exchanges? What key issues will require collaboration?
6. What issues of other interest are important to employers with respect to their participation in an Exchange?

7. Individuals without access to employer coverage with incomes below 400% of the federal poverty level (\$88,000 for a family of four) will be eligible for premium subsidies for the purchase of coverage through an Exchange. A State may operate a “Basic Health Plan” for individuals between 133% and 200% of the federal poverty level and use 95% of the tax credits that would have been available to these individuals for Exchange coverage to operate the “Basic Health Plan”. Should Kentucky establish a “Basic Health Plan”? If so, what types of benefits should be included in the Basic Health Plan?
8. One of the functions of an Exchange is to determine eligibility for Medicaid and premium subsidies. What issues need to be considered in establishing an Exchange that will determine eligibility for Medicaid and premium subsidies? How should the Exchange create a seamless system for individuals who fall back and forth between “Medicaid” eligibility and “premium subsidy” eligibility due to changes in income? How should continuity of plan coverage and provider networks be maintained for those individuals who fall back and forth between “Medicaid” eligibility and “premium subsidy” eligibility?

#### **Health Plan Participation:**

1. Health plans that wish to participate in an Exchange are required under PPACA to comply with a specified list of requirements. Beyond the PPACA requirements specified, should additional requirements be required of health plans to participate in an Exchange?
2. Should all health plans be required to participate in an Exchange and comply with the requirements or should health plans compete or bid to participate in an Exchange?
3. Should the number of benefit plans offered in an Exchange be limited or unlimited?

#### **Market Rules:**

1. Health plans participating in an Exchange are required to comply with certain requirements in areas such as marketing and network adequacy, etc. Should the same rules exist for plans sold inside and outside an Exchange?
2. Should health plans be required to offer the same product plans inside and outside an Exchange?

#### **Risk Sharing:**

1. States are required to establish a reinsurance program for individual health plans sold inside and outside an Exchange between 2014 and 2016. The program is to be funded by fully-insured and self-insured plans. What issues should be considered in establishing the temporary reinsurance program?
2. A risk adjustment mechanism is required to be established for health plans sold inside and outside an Exchange to adjust for unequal distribution of actuarial risk. What issues should be considered in establishing a risk adjustment mechanism?

3. For a health plan's business inside and outside an Exchange, PPACA establishes a single risk pool for small employer plans and a single risk pool for individual market plans as a way to mitigate adverse selection between an Exchange and the outside market. Are there issues that should be considered regarding how risk pooling works between an Exchange and the outside market to ensure a well functioning market in total?
4. States may merge their individual and small employer group markets for rating and risk sharing. What issues should be considered regarding this option?

### **Structure and Governance:**

1. An Exchange may be operated by a government agency, a non-profit entity established by the state, or the federal government on behalf of a state if a state does not wish to establish an Exchange. Should Kentucky operate its own Exchange or allow the federal government to operate the Exchange? If Kentucky operates its own Exchange, what issues should be considered in deciding which option to choose for Kentucky?
2. Various options for the structure of an Exchange are permitted: 1) joint Exchange for individuals and groups, 2) separate Exchanges for individuals and groups, 3) multiple subsidiary Exchanges each serving a distinct geographic area, or 4) regional Exchange including multiple states. Which option(s) should Kentucky choose to structure its Exchange? What issues should be considered in deciding which option to choose for Kentucky?

### **Financing:**

1. A minimum essential benefit plan is required to be sold inside and outside an Exchange. A state may choose to require additional benefits but must cover the cost of the additional benefits for individuals eligible for premium subsidies through an Exchange. What issues should be considered regarding state requirements for additional benefits above the minimum essential benefit set? What funding sources should be considered for the cost of additional benefits?

### **Consumer Outreach and Education**

1. What kinds of outreach strategies are likely to be most successful for an Exchange in enrolling individuals who are eligible for premium subsidies and cost-sharing reductions, and retaining these individuals in the Exchange? How can these outreach efforts be coordinated with efforts for other public programs?
2. What kinds of design features can help consumers obtain coverage through the Exchange? What information are consumers likely to find useful from Exchanges in making plan selections? Which kinds of enrollment venues are likely to be most helpful in facilitating individual enrollment in Exchanges and qualified health plans?

3. What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plans to select (within or outside and Exchange)? What are some best practices in conveying information to consumers relating to health insurance, plan comparison, and eligibility for premium subsidies, or eligibility for Medicaid? What types of efforts could be taken to reach individual from diverse cultural origins and those with a disability or low literacy?

**Other Comments:**

Please provide any other comments or concerns regarding a Kentucky Exchange that were not addressed in this letter.

Submit your written comments by May 17, 2011 to the Office of Health Policy, 275 East Main Street, Mailstop 4 W-E, Frankfort KY, 40601.

Sincerely,

Carrie Banahan, Executive Director  
Office of Health Policy

## Attachment B

### Stakeholder Respondents

- America's Health Insurance Plan (AHIP) (Kentucky Association of Health Plans)
- Anthem
- AARP
- Bluegrass Family Health
- Bluegrass Regional Healthcare
- CIGNA
- Delta Dental
- Humana
- Independent Insurance Agents of Kentucky
- Kentucky Association of Manufacturers (KAM)
- Kentucky Association of Health Underwriters
- Kentucky Association of Chiropractors (KAC)
- Kentucky Coalition of Nurse Practitioners & Nurse Midwives
- Kentucky Chamber of Commerce
- Kentucky Equal Justice
- Kentucky Farm Bureau
- Kentucky Medical Association
- Kentucky Optometric Association
- Kentucky Hospital Association
- Kentucky Physical Therapy Association
- Kentucky Voices for Health
- National Federation of Independent Businesses
- Norton Health Care
- United Healthcare Group

## Appendix C

### Structure and Governance: Stakeholder Perspectives

#### 1. Should Kentucky design and operate its own Exchange?

- The Chamber supports the state establishing and operating its own Exchange tailored to the needs of Kentucky citizens, rather than having the federal government do it for us. (KY Chamber)
- The Kentucky Medical Association urges the Commonwealth to establish a state-based Exchange. (KMA)
- We believe a non-profit entity should be established by the state to run and manage the Exchange, regulated by the state. (Kentucky Association of Health Underwriters)
- AARP urges states to establish an entity with the authority needed to ensure the unprecedented level of state and federal collaboration and the active cooperation of the state agencies (Medicaid, Public Health, Insurance, etc.) successful implementation of the ACA requires. The Exchange must connect with other State and national entities to provide a “one stop” and seamless process for determining eligibility and effectuating enrollment for federal subsidies, Medicaid or CHIP and other public programs. Governing bodies should include strong consumer representation and also provide the opportunity for additional issue-specific working or advisory groups to be created and to give ongoing input into the process. The governing body’s deliberations and decisions should be transparent, and should provide opportunity for public input. (AARP)
- The Exchange should be placed in an independent agency within state government and should be required to strictly comply with state laws pertaining to transparency, accountability, and public participation. The Exchange governing board should be composed of experts who have credible experience in the health insurance marketplace including enrollment experts and those who can well represent the users of the Exchange including consumers, employers/small businesses, self-employed individuals, providers, public health, and advocates. Strict conflict of interest requirements must govern relationships with insurers, who should not be represented on the board. (Kentucky Voices for Health)
- Kentucky should hang back and watch the effects of Exchange development in other states. Draw contingencies for a variety of structures, but wait until the last possible moment to choose a path. (National Federation of Independent Business/Kentucky)
- The Exchange should be run by an unbiased State-based not for profit organization. (Norton Healthcare)
- Kentucky should create and operate its own Exchange, rather than allow the federal government to do so. Additional research on potential governance structures is needed before an informed answer can be given. The Exchange should be transparent and independent. It is possible that the quasi-governmental model, which has been chosen by several other states, would work for transparency and conflicts with other state agencies. (Kentucky Equal Justice Center)
- We believe that establishing the Exchange as an independent public authority (non-profit or quasi-governmental) will both promote transparency and limit politicized decision making, ultimately benefiting consumers and helping to stabilize the health insurance marketplace. We believe the Exchange governing boards will benefit from

broad constituent representation from a wide range of stakeholders, including health plans, consumer representative, employers and providers. (United Health Group)

- The Exchange in Kentucky should be run by the state, not the federal government. The governing board should be composed of experts in the health insurance market place, consumers, and providers. Members must not be political appointees and strict conflict of interest rules must apply. Nurse practitioners should be included as representatives on the governing board with equal status and number to other members of the board. The Department of Insurance should serve as an Ombudsman or impartial agent to receive and assist consumers in obtaining resolutions and complaints. (Dr. Beth Partin DNP, APRN)
- KHA supports Kentucky operating its own Exchange instead of allowing the federal government to operate the Exchange through a non-profit entity which is separate from the state Department of Insurance. We also believe it is important that health care providers and hospitals specifically, be included on the governing authority for the Exchange. (KHA)
- Kentucky should operate its own Exchange. (KAC)
- Because Kentucky does have exceptionally strong consumer protections, we would urge that Kentucky should operate its own Exchange. (KOA)
- Kentucky should operate its own Exchange. In order to serve Kentuckians living in border counties, the state should also establish multi-state products but not multi-state Exchanges. (Bluegrass Family Health)
- Kentucky should operate its own Exchange. Transparency is a major issue to consider when choosing options. Nurse Practitioner representation on the board reviewing options is very important. A variety of stakeholders should have board representation. (Bluegrass Regional Healthcare, INC)
- Kentucky should operate its own Exchange to keep the governance close to home to react to KY-specific issues like association group plans. A private non-profit may provide the best cost containment and put all stakeholders on a level playing field. (Kentucky Association of Manufacturers)
- Anthem believes that Kentucky should design and operate its own Exchange so that it can best meet the needs of its own unique market place. It is imperative that the Exchange has reporting and fiduciary accountability, incorporated ethics standards, accountability to members, freedom from undue influence and transparency requirements. (Anthem)
- CIGNA believes that Kentucky is best positioned to craft an Exchange specific to its populations needs. Kentucky should consider creating a separate non-profit entity that is governed through input from a variety of stakeholders including business, carrier and consumer representatives. Regulatory authority should remain at the Department of Insurance to avoid the duplicity, cost, and coordination issues resulting from dual regulations. (CIGNA)

## **2. Kentucky options for the structure of an Exchange or number of Exchanges operated in the state.**

- Given that ideally one eligibility system should be utilized for both Medicaid and the Exchange, it seems that a statewide Exchange incorporating both small group and individual coverage would be preferable to improve the administrative process. CIGNA

respectfully recommends Kentucky consider operating separate Exchanges under the management of one entity. Kentucky should remain cautious, considering potential market disruption and increase in premiums possible when merging the small group and individual markets (CIGNA)

- The state should create a large enrollee pool and consider a multi-state regional Exchange with governance in Kentucky. Perhaps, operate under a consortium approach. (Kentucky Equal Justice Center)
- KYAHU recommends a single Exchange as a point of entry with a division for group and individuals with two risk pools, not mixing the two pools. Cost is a great reason to have one Exchange. (Kentucky Association of Health Underwriters)
- Kentucky should consider a joint Exchange (for administrative efficiency) for individuals and groups, or separate Exchanges for individuals and groups. Anthem opposes the development of multi-state or regional Exchanges due to difficulties related to governing laws, enforcing consumer protections, and regulator jurisdiction. (Anthem)
- Any consideration of participation in a regional or interstate Exchange must take into account the potential effects on Kentucky's existing consumer protections and regulatory authorities. In addition, coordination issues with Medicaid, KCHIP, and other state coverage programs should be carefully examined to ensure that consumer safeguards and access to coverage would not diminished in a regional or interstate Exchange. (Kentucky Voices for Health)
- Intrastate regional Exchanges should only be considered when justified by significant differences in health care cost utilization. Consumers will be better served by establishment of pools large enough to foster robust competition. Maintaining a state wide pool would also preclude redlining of high cost populations. (AARP)
- We believe that Kentucky should avoid separate localized Exchanges, which may increase administrative and infrastructure costs. Because insurance is regulated on a state level, an Exchange will generally be more flexible if it operates under the laws of a single state instead of multiple states. A state-wide Exchange should allow carriers the flexibility to design a variety of products to address the unique healthcare delivery and consumption characteristics in different regions in the State. Carriers should be allowed to vary their product offerings by health care market and geography and offer more than one benefit plan in each category. (United Health Group)
- Kentucky, a smaller state, only needs a single Exchange for individual and small groups. It would not be cost effective to create and operate different Exchanges for individuals and small groups or to have Exchanges in different regions. (Delta Dental of Kentucky)
- Allow a separate Exchange for the existing Employer Organized Association Health Plans. Allow this Exchange to be administered by the existing Master Trust. No funding will be required for this Exchange. Management is currently funded by the member associations. (National Federation of Independent Business/Kentucky)
- A joint Exchange for individuals and groups will reduce bureaucracy and represent Kentuckians. (Bluegrass Regional Healthcare, INC)
- A limited structure that preserves employer flexibility and doesn't increase administrative cost or regulatory burdens would be most favorable. Further, Kentucky needs a statewide Exchange that can adapt to Kentucky-specific issues, so not a multi-state Exchange. (Kentucky Association of Manufacturers)
- There should be one statewide Exchange for Kentucky. (Norton Healthcare)

- Exchange should be as flexible as possible and therefore operated independent from existing state agencies. Regulation of the Exchange markets should remain with DOI, who already has the expertise needed to regulate the insurance market. Transparency and accountability should be one of the goals, so it is critical that the Exchange be administered by individuals who have the proper expertise in managing and analyzing the data, records, and other financial information necessary to effectively operate laws.(KY Chamber )
- KHA believes that Kentucky should operate only one Exchange that would serve both individual and small groups. We also believe that Kentucky should explore joining with adjacent states to structure a regional Exchange. In such an arrangement, we would envision that each state would separately determine Medicaid eligibility for individuals screened and referred by a regional Exchange. (KHA)
- The oversight body of the Exchange should include consumer, physician, and other stakeholder representation. The leaders should also ensure that health plans selling insurance in Kentucky abide by the state's patient protection and provider fairness statutes and regulations. (KMA)
- The Exchange should demonstrate political independence, operational flexibility and public accountability. Provider groups from all disciplines should be represented and the chiropractic profession must be included in the decision making process and be represented on the panels overseeing the Exchange. (KAC)
- Given that ideally one eligibility system should be utilized for both Medicaid and the Exchange, it seems that a statewide Exchange incorporating both small group and individual coverage would be preferable. This would improve the administrative process as individuals change eligibility from Medicaid to the Exchange and within the Exchange from subsidy to non-subsidy or from individual coverage to small group. (Bluegrass Family Health)

### **Eligibility and Employers: Stakeholder Perspectives**

#### **1. Define small employer (50 or less or 100 or less employees)**

- We feel that initially Kentucky as well as other states should continue with the existing definition of small group employers with expansion to the larger end of the small group market in 2016. (CIGNA)
- To be successful, an Exchange needs as many lives participating as possible in order to create stable risk pools and protections against adverse selection. Therefore, the Exchange should be open to individuals and employers with up to 100 employees, not 50 employees. (KY Chamber)
- Participation in Exchanges should not be limited to employers with 50 or fewer employees. Employers with up to 100 employees should initially be allowed to participate in 2014 and even larger employers should be allowed to participate in 2017 as allowed under the ACA. This will increase the size of the pool covered under the Exchange and extend tax credits to as many businesses as possible. Further data may be needed to examine the impact that employer size may have on the market. (Kentucky Voices for Health)

- We believe that the threshold for small employers should be 100 employees enrolled in coverage. We do not see an underwriting advantage to making the cutoff at 50. (Delta Dental of Kentucky)
- KYAHU recommends it start at 2-50 in 2014. (Kentucky Association of Health Underwriters)
- Anthem believes that definition of small employer should be limited to 50 until 2016. (Anthem)
- We believe that Kentucky should select 50 employees as the initial size limit for the small group market. Limiting the small group market will also minimize market disruption and avoid overtaxing Exchanges' administrative systems as they get up and running. (United Health Group)
- KHA recommends that the state health benefit Exchange be limited to individuals and small groups, defined as 50 or fewer employees. (KHA)
- Definition of a small employer: 100 or less employees. (Bluegrass Regional Healthcare, INC)
- KAM would prefer the more limited definition of 50 or less. If for no other reason than, to limit market disruption and an easing into the new Exchange marketplace. (Kentucky Association of Manufacturers)
- Small employers should be defined as 50 or less employees. (Kentucky Farm Bureau Mutual Insurance Company)
- Small business employers should be defined as 100 or less employees. (Dr. Beth Partin DNP, APRN)
- Beginning in January 2014, states should modify their existing definition of "small business" (in Kentucky that would be employers with 50 or fewer workers) to conform to the federal definition of 100 eligible workers. (Humana)
- KRS 154.12-325 establishes that a small business has fewer than 50 employees. (National Federation of Independent Business/Kentucky)
- In order to increase the risk pool, we would define small employers as 100 or less employees. To the extent possible, employees should have as many product options as possible. (KOA)
- Definition of a small employer should be employers whom have 2 to 100 employees. (Bluegrass Family Health)
- We believe that the small employer definition should remain at 50. The definition can be expanded after the program has worked through any major issues. (Norton Healthcare)
- We have no preference on initial inclusion of 50-100 employee businesses. (AARP)

## **2. Exchange participation for large employers beginning in 2017**

- We do not feel that the Exchanges should be expanded to include employers with more than 100 employees.(CIGNA)
- All employers should be allowed to participate in the Exchange as an alternative to the open market. There should be no upper limit, but it is doubtful that large employers who could self-insure would participate. (National Federation of Independent Business/Kentucky)
- Large employers should be allowed to participate in 2017 as allowed under the ACA. This will increase the size of the pool covered under the Exchange and extend tax credits

to as many businesses as possible. Further data may be needed to examine the impact that employer size may have on the market. (Kentucky Voices for Health)

- KYAHU recommends that Exchanges cap groups at 100 employees due to claims experience being a part of each health renewal for those groups with over 100 employees. We also believe that the subsidy should follow the employee in the group and not only be available if they leave and go to the Exchange. (Kentucky Association of Health Underwriters)
- Again, Anthem opposes allowing the large employers to purchase coverage through the Exchange. Larger groups have different needs and tend to be more sophisticated purchasers of coverage. (Anthem)
- We believe individuals and small groups, defined as 50 or fewer employees should be maintained in 2017 and beyond so that the Exchange is not expanded to larger employers due to commonalities with the individual and small group. Additionally, KHA is opposed to expansion to allow large employers in the Exchange because we believe this would encourage employers to abandon group coverage and result in more Kentuckians being cast into the individual market, with potentially higher costs for them. (KHA)
- As we have stated, large employers tend to have better resources for making health insurance decisions. Forcing them to buy in the Exchange doesn't seem to make sense. However, there should be the flexibility for large employers to try and find the best cost product inside or outside of the Exchange. (Kentucky Association of Manufacturers)
- Larger employers should be allowed to participate in the Exchange in 2017, and there should not be an upper limit on participation. (Kentucky Farm Bureau Mutual Insurance Company)
- No. (Bluegrass Regional Healthcare, INC)
- The group should be expanded to an even greater number in 2017 by adding Large employers. Limits on the size of the groups will need to be examined as data is gathered to re determine if there are drawbacks to enrolling very large groups. It would seem that permitting large groups would increase the size of the pool and thus, decrease rates to the consumer. (Dr. Beth Partin DNP, APRN)
- Consistent with the belief that more lives equals great stability, large employers should at least be considered for participation in 2017. However, the state should carefully examine the effectiveness of an Exchange with available data and engage the stakeholder community prior to implementing such a change. (KY Chamber)
- Kentucky should concentrate on ensuring an effective individual and small group marketplace first and then consider expanding participation in the Exchange only after the basic needs of the Exchange are being effectively met, including the consumer and provider protections and that sufficient enforcement mechanisms are in place. (KAC)
- Large group (100+ employees) should not be allowed to participate in the Exchange. (Bluegrass Family Health)
- We do not believe that the Exchanges should be expanded to large employers with more than 100 employees. Large employers generally enjoy market leverage and economies of scale that permit them to select and enroll in high quality private health plans for their employees at competitive prices. (United Health Group)
- Large employers should not enter into the Exchange at this point. Premiums should be stabilized before large groups enter into the Exchange. In 2017, large employers should be allowed to participate in the Exchange without an upper limit. Their ability to

participate should not preclude them from access to other options such as self insuring or utilizing markets outside the Exchange. Providing options and competition will likely provide the best long-term outcome for Kentucky consumers. The Exchange, or the insurance carriers participating in the Exchange, may want to consider segmenting risk pools for individuals, small, and large group markets. (Norton Healthcare)

- We have no preference on expansion to large employers in 2017. (AARP)

### **3. Should there be participation requirements for employer groups in an Exchange**

- We strongly encourage Kentucky to survey the smaller employers to determine what, if any, parameters should be place on this group relative to Exchange participation.(CIGNA)
- No restrictions should be adopted that are more onerous than the ones currently in the market. The object of the exercise is to increase the purchase of health insurance, not add to the bureaucracy and barriers. (National Federation of Independent Business/Kentucky)
- Yes, Kentucky should consider requiring employers purchasing coverage for their employees in the Exchange to have a minimum percentage of their employees participating. Also, we support employers purchasing coverage in the Exchange being required to make a minimum contribution toward their employees' health plans. (Anthem)
- There should be a minimum of 50 employees participating in an employer group in the Exchange with no minimum level of employer contribution required. (Kentucky Farm Bureau Mutual Insurance Company)
- Generally, we believe that some form of participation requirement makes sense for employer groups within the Exchange to assure a balanced risk pool. Requiring all employees of an employer within the SHOP Exchange to purchase from within one actuarial level also helps to keep costs down by mitigating adverse selection. (United Health Group)
- KAM wants to preserve the employers' flexibility without increasing costs through additional administrative burden. Having a minimum participation rate seems to make sense, so that there isn't duplication of administrative services. Same with the choice of products, flexibility is good, but a greater emphasis should be placed on not increasing administrative costs. (Kentucky Association of Manufacturers)
- We do not advocate minimum participation requirements. We have many years' experience in offering and pricing voluntary dental coverage in which we cover any employee who opts to purchase the coverage regardless of participation rates. The individual and small group Exchange products will, by design, be community rated. It will be unnecessary to exclude some employees in one group simply because of insufficient participation in that employer. The community rating will mitigate the adverse selection problem. (Delta Dental of Kentucky)
- Yes, there should participation and contribution requirements, just as participation levels and contribution levels save groups and insurance carriers from adverse selection, it will also save the Exchange from these same issues. Also, employees should not be allowed to opt out of their group plan if the group is in the Exchange, opting for individual coverage in the Exchange, this will help both the employer and the Exchange

from undue administrative and underwriting issues. (Kentucky Association of Health Underwriters)

- There should not be participation requirements that would prevent employers with a very small number of employees (maybe 15 or fewer) from participating as a group, if such participation would benefit those employees. Likewise, employees of very small businesses should be allowed to participate in the Exchange as individuals. (Dr. Beth Partin DNP, APRN)
- The Chamber encourages the state to consider a “defined contribution” approach that would give an employee full control over decisions relating to their coverage. Setting minimum employer contribution requirements and forcing employees to choose from a single tier will likely serve to limit choices for employees and decrease participation from employers. (KY Chamber)
- If group participation requirements are set, alternate coverage of employees should count toward the required percentage. (KOA)
- Yes, we believe there should be participation requirements, such as: a.) minimum participation, b). minimum employer contributions, c.) limited number of plans to choose from, d.) employees can choose program and carrier. (Bluegrass Family Health)
- Yes, employers should have participation requirements to protect the Exchange against adverse selection. Otherwise, employers will dump all sick employees into the Exchange. Employers should also have a minimum contribution, otherwise employers could enter the Exchange and not pay for employee benefits and the providers get stuck with the bill. There should also be a limit or ceiling on high deductibles for employees. (Norton Healthcare)

#### **4. Exchange design features likely to be important for employer participation**

- The web portal must be intuitive, easy to navigate, and easy to understand. Most importantly, coverage options, while plentiful, must be presented in such a way that will not confuse employers or employees. Price and quality of plans must be transparent and easy to compare. Offering a seamless transition from traditional purchasing will increase employer participation. (KY Chamber)
- Flexibility will be a key factor in an employer’s decision to participate in the Exchange. (KOA)
- Create a product that will provide immediate savings to small businesses and individuals by decreasing premiums. Include Nurse Practitioners, Nurse Midwives, and Mental Health Nurse Practitioners in the Exchange. Make greater use of Managed Care utilizing Nurse Practitioners as Gatekeepers. (Bluegrass Regional Healthcare, INC)
- In Kentucky today, small employers already have a wide variety of choice among health plans and plan design in a guaranteed issue environment. Maintaining a similar level of choice and competition will be critical to attracting small business employers to the Exchange. (United Health Group)
- The Exchange should facilitate enrollment and billing of employer groups to minimize bookkeeping and paperwork on the part of the employer. Employers should be allowed to use premiums to incentivize health behaviors on the part of their employees, such as tobacco use and involvement in wellness incentive programs. (Kentucky Voices for Health)

- KAM believes the Exchanges could present an opportunity to reduce costs to employers through transparency and increase competition, while we are concerned about additional employer burdens that will raise costs and reduce flexibility. To that end it should be easy for those small employers eligible for tax credits to access those programs.
- On the Exchanges, dental plans should be separately priced and separately offered from medical plans. This is necessary to provide consumers with an “apples to apples” plan comparison. It will also ensure transparency in pricing and promote greater competition – consumers will benefit from both in terms of cost and choice. This transparency of benefits and pricing will mirror the current market model and is critical for informed consumer choice. (Delta Dental of Kentucky)
- Design features that are likely to be important for employer participation include: a.) ease of administration, b.) carrier choices, c.) electronic enrollment and billing. (Bluegrass Family Health)
- Minimal regulatory requirements regarding employer required notices, reporting, filing etc. Timely notice of renewal for participants. Clear communication about rates, benefits, and options at renewal. Administrative efficiencies, standardization, making data/information sharing easy and efficient. A single point of entry for all Exchange consumers and a single regulatory authority for the Exchange. Emphasis on wellness. Ability to steer our employees to a Norton facility. (Norton Healthcare)
- Best practices are already in place in the Employer Organized Association Health Plans. These programs are governed by business owners and their representatives for group purchasing and cost management. (National Federation of Independent Business/Kentucky)
- To ease transition to the Exchange for small employers who currently offer coverage to their employees and who choose to renew their plans through a SHOP Exchange, Anthem believes that employers should be allowed to select specific health plans and carriers for their employees within the small group Exchange. Kentucky should also consider strategies for helping small employers determine their eligibility for the small employer tax credit, and also any processes that could make their application for and receipt of the credit as streamlined and as administratively simple as possible. (Anthem)

##### **5. Considerations that are important in facilitating coordination between employers and Exchanges and key issues requiring collaboration**

- The Chamber recommends that the Exchange create a notice process that would alert an employer when an employee’s coverage is “unaffordable”. Following this notice, an employer must be granted a remedial opportunity to make a premium contribution so that they employee’s coverage is no longer “unaffordable”. (KY Chamber)
- Kentucky should consider offering services that are designed to ease the administrative burden of small business employers, and carefully evaluate the potential effects of well-intentioned Exchange regulations that could ultimately result in increased prices and destabilization in the small business market. (United Health Group)

- KYAHU believes in order to preserve the group and individual market; individuals eligible for group coverage should remain within the group. This will protect insurers from employers who will try to move individuals in or out of group to improve their underwriting options, changing dynamics of the individual pool. Also, due to costs KYAHU would recommend state Exchanges be a “Virtual Exchange” (Compare cost of Exchange in Utah verses Mass.) This ultimately affects cost of coverage. (Kentucky Association of Health Underwriters)
- Kentucky should consider strategies for helping small employers determine their eligibility for the small employer tax credit, and also any processes that could make their application for and receipt of the credit as streamlined and as administratively simple as possible. (Anthem)
- Employers need to be assured that administrative costs of participating in the Exchange are minimized. This means that they will not employ additional people to administer benefits or work with employees. (Delta Dental of Kentucky)
- Communication is critical. (Norton Healthcare)
- Keeping the structure of the Exchange simple, allowing employers and their representatives like KAM to be included in the governance, utilizing existing resources like agents inside and outside of the Exchange, and providing information transparency. The more complicated this is the less likely employers will engage in the process. (Kentucky Association of Manufacturers)
- The fast track to developing an Exchange system would be to create a separate Exchange for the current Employer Organized Association Health Plans, jump start the process and implementing a successful model. (National Federation of Independent Business/Kentucky)

## **6. Other interests important to employers with respect to participation in the Exchange**

- We would urge the state to do no harm to programs that are working, including the high risk pools, employer tax credits, and association health plans. The state should continue to work closely with employers as an Exchange is developed, modified and evaluated. (KY Chamber)
- No comment at this time. (Norton Healthcare)
- For small groups, the functions that are currently handled by agents and/or the insurer, those resources must continue to be available to these groups at no additional cost. (Delta Dental of Kentucky)
- AARP has no position at this time. (AARP)
- Aggregate premiums can entice employers. To encourage as many employers as possible to join the Exchange, ease of participation is paramount. Payment processes within the Exchange should be no more burdensome than those in the outside market. The smaller administrative burden created by allowing employers to pay a single premium may promote higher participation. (Kentucky Equal Justice Center)
- Avoid adverse selection caused by subsidized employee jumping in and out of group after the renewal was generated based on existing census by insurance carrier. Insurance carriers must maintain consistency in order to underwrite groups properly. The Exchange should offer four plans designed by HHS. Outside the Exchange carriers should offer the same plans but should also have the ability to

design other options giving employers more choice. (Kentucky Association of Health Underwriters)

- Ease the transition to the Exchange for small employers who currently offer coverage to their employees and who choose to renew their plans through a SHOP Exchange; Anthem believes that employers should be allowed to select specific health plans and carriers for their employees within the SHOP Exchange, which the ACA supports. Finally, as noted above, Kentucky should consider strategies for helping small employers determine their eligibility for the small employer tax credit, and also any processes that could make their application for and receipt of the credit as streamlined and as administratively simple as possible. (Anthem)
- The only issue that will be important to employers will be the bottom line of cost of coverage. If it is more expensive than what they currently have, there will be little enthusiasm. (National Federation of Independent Business/Kentucky)
- It would seem that, outside of premium costs, other interests important to employers related to participation in an Exchange would be reduced administrative costs as well as ease of enrollment and procedures for collecting premiums from employers and employees. (KHA)
- KAM believes the Exchanges could present an opportunity to reduce costs to employers through transparency and increased competition or burden employers and raise costs with limited choice and flexibility. We are focused on expanding flexibility, transparency and manufacturers access to information. That being said we want to make sure that KAM's association plan can continue to exist once the Exchange goes into effect. (Kentucky Association of Manufacturers)
- Exchange encourages healthy behaviors and lifestyle modification to lower premiums. Evidence-based coverage, implement health plan design to create value-based plans, transparency of price for services and procedures so employers and employees can make educated choices and encourage coordinated care. (Bluegrass Regional Healthcare, Inc)

**7. Individuals without access to employer coverage with incomes below 400% of the federal poverty level (\$88,000 for a family of four) will be eligible for premium subsidies for the purchase of coverage through an Exchange. A state may operate a "Basic Health Plan" for individuals between 133% and 200% of the federal poverty level and use 95% of the tax credits that would have been available to these individuals for Exchange coverage to operate the "Basic Health Plan". Should Kentucky establish a "Basic Health Plan"? If so, what types of benefits should be included in the Basic Health Plan?**

- Given the relatively small pool of individuals that will be eligible for the Exchange, the state should carefully consider the potential unintended consequence of creating a Basic Health Program. The Basic Health Program has the potential to reduce the eligible individuals from the Exchange pool, reducing the state's ability to equalize costs and bear risk across the largest available risk pool. (CIGNA)
- We believe that it would be prudent for Kentucky to thoroughly evaluate the Basic Health Plan (BHP) option, including the extent to which it would benefit consumers as well as the impact it would have on the Exchange. Key economic considerations and policy issues must be evaluated before operating BHP. (United Health Group)

- Kentucky should offer a “Basic Health Plan”. Preventive services and screening should be included among the benefits. In addition, individuals who can demonstrate reductions in risk factors such as weight loss, tobacco cessation may qualify for reduced payments. (Bluegrass Regional Healthcare, INC)
- Kentucky should establish a basic health plan if it is voluntary and does not encourage adverse selection. (Kentucky Equal Justice Center)
- Undecided (Anthem)
- Yes, it is our opinion that Kentucky should establish a “Basic Health Plan” and that the benefits to be included should be similar to current “Basic Health Benefit Plans” as described in KRS 304.17A-096. (Bluegrass Family Health)
- Yes, Kentucky should have the “Basic Health Plan.” Preventive care must be included.(Norton Healthcare)
- Kentucky already has a basic health plan available, but it is not a popular option in the current market. Exchange policies need legislation to make all state health benefit mandates in excess of federal mandates optional coverages. (National Federation of Independent Business/Kentucky)
- KHA is opposed to the state operating a “Basic Health Plan” for individuals between 133% and 200% of poverty. First, there are already several levels of coverage defined in the ACA, and most people do not want limited benefits. Kentucky experienced this in the past when legislation mandating a basic health plan was passed, a plan was developed with limited coverage, but the plan was not purchased because people wanted more benefits. More importantly, we do not believe the state should be in the business of operating a health plan. Our concerns with a state-run plan are that the state could mandate inadequate provider payment rates, such as Medicaid rates, to lower premium costs for the state, and even to require that providers participate in the state-run basic benefit plan as a condition of participation in Medicaid. (KHA)

**8. One of the required functions of an Exchange is to determine eligibility for Medicaid and premium subsidies. What issues need to be considered in establishing an Exchange that will determine eligibility for Medicaid and premium subsidies?**

- We think that the state should get the Exchange for the private market up and running successfully.(CIGNA)
- The Exchange must have a “No Wrong Door” Policy. (Kentucky Equal Justice Center)
- A simplified set of eligibility rules should drive the system design. Steps should be taken to ease consumer navigation and administrative burden, including a standard template to capture personal information and pre-populating forms with known information. As a first step, we encourage an analysis to determine what, if any continuity issues may exist in a reformed marketplace. Second, depending on results of any analysis, a dialogue should take place between regulators and health insurers to determine if collaborative solutions exist or can be developed as needed. (United Health Group)
- The Exchange and the Medicaid and KCHIP programs should be streamlined to require a single application for all health plan options and should accept electronic applications without the need for paper documentation. Assistance should be readily available in cases where eligibility cannot immediately be determined. Adequate information should be collected at the time of application to ensure individuals who later become eligible for Medicaid do not have to submit additional documentation. Exchanges should see it

as their responsibility to ensure the continued enrollment of eligible individuals and families for tax credits or public programs. (Kentucky Voices for Health)

- No comment at this time. (Norton Healthcare)
- If the subsidy follows the person, then a great deal of transition and administrative costs is eliminated if and when a person falls back and forth between the two. This determination should be made on an annual basis if possible to insure stability of the insurance market. (Kentucky Association of Health Underwriters)
- Anthem recognizes that there are complicated issues surrounding the interactions between Medicaid and the Exchange. While we are engaging in discussion on these issues, we have not yet come to a finalized position. While seamlessness will be important, it is also critical to note that significant differences exist with respect to the benefit requirements, cost-sharing levels and networks associated with each type of coverage. (Anthem)
- It is virtually important that the Exchanges are structured so that transitions between Medicaid, state health care programs, federally subsidized coverage and fully private pay are centralized, prompt, seamless, and ensure continuity of care. There should be uniformity, however, from the consumer's view, with the individual able to report a change in income to the Exchange and to be granted Medicaid coverage promptly and without having to interact with multiple agencies. (AARP)
- KHA believes it is extremely important that the Exchange coordinate with the Medicaid program and, specifically, that more generous criteria not used by the Exchange to determine eligibility for Medicaid. The Kentucky Medicaid program reimburses hospitals, on average, only about 85 percent of the actual cost of delivering care to Medicaid patients. The expansion of Medicaid to additional enrollees under health care reform will further exacerbate these existing hospital losses. Therefore, the goal of the Exchange should be to direct individuals into the purchase of private health insurance and not into the Medicaid program. We believe these problems can be avoided by having the Exchange only screen individuals for potential Medicaid eligibility and then refer them to DCBS to perform actual eligibility verification. (KHA)

**9. How should the Exchange create a seamless system for individuals who fall back and forth between "Medicaid" eligibility and "premium subsidy" eligibility due to changes in income?**

- Once eligibility for either subsidy is established, the state should consider a one year lock in for the initial plan choice.(CIGNA)
- To create seamless system of care between eligibility for Medicaid and premium subsidies, providers must be allowed to participate on the Medicaid and Exchange panels. Also, a plan should be offered through the Exchange that parallels Medicaid coverage. (KOA)
- No comment at this time. (Norton Healthcare)
- In order to provide a seamless system for individuals who frequently switch between Medicaid and subsidized coverage, it would be helpful if the same Medicaid managed care plans would also offer private coverage in the Exchange. (KHA)

**10. How should continuity of plan coverage and provider networks be maintained for those individuals who fall back and forth between "Medicaid" eligibility and "premium subsidy" eligibility?**

- The most ideal structure would be one integrated system used to determine eligibility for Medicaid, CHIP, and premium subsidies. Ideally, each carrier that provides Medicaid coverage and coverage in the Exchange would also offer their Medicaid provider network and Medicaid benefits within the Exchange. This would allow individuals who migrate between Medicaid eligibility and Exchange subsidy eligibility to elect to stay within the same network and same benefit structure. (Bluegrass Family Health)

#### **Functions:**

#### **1. Beyond the specifically listed functions, are there additional functions that should be considered for an Exchange?**

- We feel strongly that the Exchanges should focus on the list of functions specifically outlined by PPACA.(CIGNA)
- The Kentucky Health Insurance Exchange should be a state run marketplace that offers standardized health care plans for individuals, some of whom are eligible for federal subsidies. (Bluegrass Family Health)
- The Exchange should consider performing functions that help to create a positive consumer experience, such as streamlining eligibility and enrollment processes and providing effective plan comparison tools. Functions that add administrative cost without improving the consumer experience or improving choice and competition should be avoided. (United Health Group)
- Anthem believes that states should work to design “facilitator” Exchanges that will build upon existing state and federal law and thereby mitigate the risk of creating administrative burden, higher costs and less choice for individuals and small employers. The Exchange should not manage the following: price regulation (should remain a function of the Insurance Regulator); billing and premium collection (should be managed by health plans); and broker commissions for sales outside of the Exchange (health plans should retain authority to set commissions). (Anthem)
- Generally speaking we want Exchanges to be as simplistic as possible. One possible additional function would be providing consumer claims assistance channels, which could direct consumers to work with an agent, a call center, etc. (Kentucky Association of Health Underwriters)
- The KY Association of Manufacturers believe it is critical to preserve what’s working in our health care current system while addressing the inefficiencies and problems that cost manufacturing in Kentucky and the United States billions of dollars a year. The cost of health insurance threatens the ability for Kentucky manufacturers to compete in the global economy. (Kentucky Association of Manufacturers)
- Transparency is essential in all activities, cost containment, reduced operational costs, and monitor for unintended consequences and make midcourse changes as needed. (Bluegrass Regional Healthcare, INC)
- Functions listed are appropriate. (Norton Healthcare)
- No. (National Federation of Independent Business/Kentucky)
- AARP sees Exchanges as strong purchasing organizations, not passive “portals.” They must drive the value agenda for health care called for throughout the ACA and bring the best plans and services to consumers with affordable premiums and cares costs. The

process of determining whether a health plan may participate should involve robust competition with ongoing monitoring, evaluation and enforcement necessary to ensure high performance by participating plans and to address deficiencies. Exchanges should use a competitive bidding and negotiation with plans seeking to become Qualified Health Plans. Exchanges should not be required to accept all plans that wish to participate, but instead should be able to limit the number of plans available to ensure consumers and employers are able to see value for premium dollars spent. The Massachusetts Connector has done focus groups on this issue and found a strong consumer preference for a small “manageable” number of plans. (AARP)

**2. Navigator programs are required under the new law. What issues should be considered in establishing a Navigator program?**

- In the establishment of the Navigator program, Kentucky should be sure to select agencies, groups or organizations that have a detailed familiarity with the insurance industry as well as access to certain populations within the state. Kentucky should also consider a certification or licensing process for these navigators to ensure their effectiveness. (CIGNA)
- The Exchange needs a strong and diverse Navigator Program. Kentucky must ensure that there are a sufficient number of Navigators who possess the experience and capacity to serve disadvantaged, hard-to-reach, and culturally or linguistically isolated populations. Further, effort should be made to recruit Navigators from the communities they will serve. (Kentucky Equal Justice Center)
- As consumer advocates, we believe the navigator program is one of the critical building blocks to a reformed health care system that merits serious attention and development. We believe that navigators must have the consumer as their client, conflicts of interest should be prohibited, provide information to consumers, effectively serve low-income and disadvantage populations, undergo a form of screening or educational process, and the Kentucky Department of Insurance should serve as the ombudsman to receive consumer complaints and resolve disputes involving navigators. (Kentucky Voices for Health)
- Navigators will receive grants from the State to provide this function in the new insurance market and it is critical that they are accountable to the State and to consumers that their guidance is high-quality and certified. (Kentucky Association of Health Underwriters)
- Anthem believes that “Navigators” should be impartial and that their roles should be limited to the requirements set forth in the ACA. (Anthem)
- Consumers will be best served by having a variety of portals available to them and should have the option to purchase coverage with or without the use of agents or brokers. (AARP)
- Due to the fact that we represent many large employers we have found that they have developed or procured the resources/services needed to make wise health insurance choices. Most of the time this is with a licensed health insurance agent or consultant. We wouldn’t want to lose that expertise. A navigator program may be of greater assistance for smaller employers. If so, the program should be designed to provide the same type of service for small employers that large employers have today. Insurance agents and consultants should be included. (Kentucky Association of Manufacturers)

- I believe that “Navigators” should be well-trained and knowledgeable of the product before engaging with employers and individuals. Consideration of racial and ethnic disparities is essential. Protection for vulnerable consumers. Evaluation and monitoring of the “Navigator Program”. (Bluegrass Regional Healthcare, INC)
- Kentucky should strive for simplification of educational materials and widespread availability of these materials to consumers. It must be ensured that “navigator” programs are developed and implemented with the maximum amount of transparency possible. A program “certify” authorized Navigator groups, personnel and “agents” should be established –again with the maximum amount of transparency as possible and the ability to “audit” the effectiveness and compliance of the “Navigator” groups and personnel to ensure compliance with all established standards. (KAC)
- A process could be established by which they could qualify as “certified” representatives/agents within the Navigator framework. Such a process should ensure transparency and eliminate any carrier or provider bias. Consider policies to ensure that the commissions paid for plans sold in the outside market do not cause brokers and agents to steer consumers away from the Exchange. (KAC)
- A “Navigator Program” must be able to provide information to consumers in an easily understood fashion and be accessible to a wide range of individuals. It is likely that individuals applying for insurance through the Exchange will have been previously uninsured, and thus need more assistance in navigating the system. The “Navigator Program” should be sensitive to these needs. Also, a “Navigator Program” should have specific provisions for helping small and new business owners as well. Information about the Exchange’s health benefit plans and the various health plan choices should be readily accessible to consumers in a variety of formats, including via the insurers’ web sites and printed material. (Dr. Beth Partin DNP, APRN)
- A strong Navigator program to educate the public and raise awareness of the availability of qualified health plans will encourage consumer interest and participation in the Exchange. To support true consumer choice, it will also be important that Navigators meet the requirements in the ACA for distributing fair and impartial information. For this reason, insurers, brokers, plans and those in their provider networks, and others that may have financial interest should be excluded. (AARP)
- “Navigator” Program issues: a.) Navigators should be licensed agents b.) Navigators should be employees of an administrative company providing services for the Exchange. (Bluegrass Family Health)
- The Navigator program will be a significant part of an Exchange. These Navigators must understand complex insurance matters and be able to articulate them in layman’s terms to consumers with little to no knowledge of insurance programs. Navigators should be well versed in Medicare, Medicaid and KCHIP to identify if a consumer is eligible for another program and be able to enroll them in the appropriate program. Other considerations: who is eligible to be a Navigator?; how will navigators be compensated?; how will they operate?; how can it be ensured that there are no conflicts of interest?; do they need to be licensed?; will they fall under the same regulatory authority as licensed agents?; how will Navigators be policed? And by who? Another consideration is on potential language and educational barriers. Use of different and various forms of communication as we have found that employees respond to different methods. (Norton Healthcare)
- Cost minimization. (National Federation of Independent Business/Kentucky)

### 3. What should the role of agents play in assisting individuals with coverage in the Exchange?

- The brokers and consultants should continue to play a vital role in assisting individuals and small businesses navigate, negotiate, and understand the range of opportunity and products available to meet their specific needs. (CIGNA)
- State-licensed, agents should continue to play an important role in an Exchange. We encourage the state to authorize agents to assist employers and employees in an Exchange, as they have in the insurance market for many years. (KY Chamber)
- An agent's role in the Exchange should be as the "Advocate" for the employer and employee on issues concerning purchasing and renewing programs offered through the Exchange. (Bluegrass Family Health)
- KVH believes insurance agents should be permitted to play a role in Exchanges, but their use should not be required. Agents can be an important source of consumer information and assistance, but care should be taken to minimize conflicts of interest and ensure that consumers are not directed by agents only to plans participating in an Exchange that are offered by companies they represent. Agents should complement the role of navigators; they must be impartial and their role is limited to the requirements outlined in the Affordable Care Act.
- Anthem believes that brokers should continue to play a key role in the sale of health insurance inside and outside of Kentucky's Exchange. This is especially true for the small group market, in which brokers often help small businesses with more than the simple election of a health insurance plan. Brokers must not have incentives to channel business solely inside or outside of the Exchange. The role of brokers should be to complement the role of navigators. (Anthem)
- Health insurance agents and brokers have well-served the health insurance delivery system for years and will continue to do so in the new market. They act as intermediaries and advocates on behalf of the consumer on claims issues and resolution with the carrier. Anyone purchasing insurance coverage through the Exchange should have the option to work with an agent or broker and receive their services. (Kentucky Association of Health Underwriters)
- Agents can be useful but must be regulated. Safeguards must be in place to make sure that agents are not steering consumers away from an Exchange or encouraging adverse selection. Additionally, the State may wish to study the benefits of aligning incentives so that the rewards for placing a customer inside and outside the Exchange are equivalent. (Kentucky Equal Justice Center)
- AARP has opposed state proposals to require brokers to be involved and paid for in all Exchange sales. Mandating agent and broker involvement in all sales could increase consumer and federal tax subsidy costs. The cost of using and not using brokers and agents should be clearly disclosed to consumers and employers. (AARP)
- Agents should be included inside and outside of the Exchange. Our members see them as the experts. (Kentucky Association of Manufacturers)
- We believe agents perform valuable purchasing services for consumers especially for small employers and individuals who often do not have the time, experience or personnel resources to make informed purchasing decisions. In the Exchange model, agents would assist individuals in making price and benefit comparisons of Exchange offerings. However, the amount of work should be less so the agent fees and or

commissions can be restricted as part of the Exchange rules with savings to the consumer over the present model. (Delta Dental of Kentucky)

- Because agents are knowledgeable about the insurance industry, they do have a role to play in assisting individuals and employers in obtaining health insurance coverage. However, there should be rules in place to prevent conflicts of interest and to prevent agents from directing consumers solely to companies they represent. The use of an agent should not be required. (Dr. Beth Partin DNP, APRN)
- Agents should be ethical in all dealings with individuals. (Bluegrass Regional Healthcare, INC)
- In their current role, agents act as “navigators” for the existing insurance markets. They provide awareness, education, customer service, and make recommendations. As you know, agents are required to be licensed and are regulated by the State Department of Insurance. Agents should be eligible to be “navigators” in the Exchange in addition to their current, and or other roles. (Norton Healthcare)
- Agents should continue their current roles as advocates for their insureds. (National Federation of Independent Business/Kentucky)
- The need for agents to assist with enrollment in the Exchange should be reduced if the Exchange is designed to be consumer friendly and easy to understand and use. Agents could be used as “Navigators” and paid by the Exchange if they refer or help in enrolling individuals in the Exchange. (KHA)

#### **Health Plan Participation:**

##### **1. Health plans participating in an Exchange must meet federal requirements, should additional requirements be applied?**

- Promulgation of consistent and objective participation standards will enable a competitive marketplace and result in more choices for consumers. (CIGNA)
- The state should allow a wide range of plans, with varying levels of benefits, to be offered through an Exchange. The state should permit any plan meeting the minimum requirements of the PPACA to participate in an Exchange, and not impose any additional requirements that may limit coverage options for employers and employees. The state needs to take a serious look at the viability of current state-imposed mandates, which have served to significantly increase health insurance costs for employees. (KY Chamber)
- Kentucky should require that Exchange plans have reasonable rate increases and provided quality services and care. By providing additional requirements regarding price and quality, the Exchange can ensure better services are available. (Kentucky Equal Justice Center)
- Kentucky should avoid excessive, burdensome requirements for becoming a Qualified Health Plan (QHP) that do not help demonstrate the basic goals of solvency, quality and efficiency. State-based Exchanges should avoid duplication of existing regulatory functions regarding rate review, licensing, and market conduct, and should rely to the extent possible on existing review standards established by national accreditation agencies such as NCQA – for use in the health plan certification process. (United Health Group)
- KMA opposes mandates and additional regulatory burdens as they tend to increase costs. (Kentucky Association of Manufacturers)

- The certification criteria should be driven first and foremost by consumers' and small business employees' need for affordable, adequate and accessible coverage. Many low-income and medically-underserved individuals who will enroll in Exchanges interact with the health care system through community health centers, public health departments, and other community providers. (Kentucky Voices for Health)
- The Exchange should permit separate standalone dental products and should require that all dental benefits, whether standalone or unified with medical benefits be separately priced and described. Allowing specialized carriers who focus only on dental to offer and price dental benefits separately from medical carriers will increase competition, provide choice and drive down costs for consumers. We believe that allowing full service health carriers to embed pediatric dental benefits within an Exchange-offered Qualified Health Plan runs counter to the goals of transparency, comparison shopping, consumer choice and proportionate allocation of federal and state subsidies and tax credits. (Delta Dental of Kentucky)
- Requirements for participation must be kept at the bleached, bare bones level to encourage any participation in the program. Once again, the only consideration of the success of the Exchange for business owners will be whether the coverage is more affordable than what they currently have. (National Federation of Independent Business/Kentucky)
- Health plans offered in a KY Exchange should not be exempt from KY statute. Being a group of health care providers, we believe it is imperative to allow for competition in the marketplace. Health plans should be required to allow equal participation from all provider types within their respective scope of practices. (KAC)
- Kentucky health plans currently operate under both state and federal law, so BFH believes that no further requirements should be placed on health plans not already codified in law. (Bluegrass Family Health)
- As long as a health plan or insurance carrier meets the State Department of Insurance requirements and is qualified based on the PPACA requirements, no other requirements should be imposed. Health plan participation should not be restricted to a traditional insurance carrier. Exchanges should be open to the development of new delivery systems such as Accountable Care Organizations (ACOs) and other innovations. (Norton Healthcare)
- All plans must be held to consumer and provider protections that already exist in state law; we feel any plan meeting such standards should be allowed to participate in the Exchange. KHA does not believe state Exchanges should engage in establishing additional, new criteria that would restrict the number of participating plans. It is especially important that state Exchanges not impose additional restrictions – either through additional criteria, rate setting, or bidding among plans in order to participate. **KHA prefers that a state Exchange function like a clearinghouse where all certified plans could participate.** (KHA)
- The Exchange's selection standards should include several factors: affordability; the quality and adequacy of the provider network, including inclusion of nurse-managed health clinics; collection of data on race and ethnicity to determine disparities and systems to reduce these disparities; quality improvement systems; data collection and reporting requirements to assess quality and efficiency; access to providers and emergency care; and marketing practices. Ongoing monitoring, evaluation and

enforcement are necessary to ensure high performance by participating plans and to address deficiencies. (AARP)

- In order to maximize choice, competition and health plan participation, Anthem opposes the establishment of additional requirements on Qualified Health Plans beyond those required by the ACA. (Anthem)

**2. Should all health plans be required to participate in the Exchange or should health plans compete or bid to participate in an Exchange?**

- Participation in the Exchange should be optional while still allowing for a free market participation off the Exchange. (CIGNA)
- No, such mandates will return us to the days of HB 250 and destroy the last vestiges of Kentucky's health care marketplace. (National Federation of Independent Business/Kentucky)
- All health plans should be required to participate in the Exchange. (Bluegrass Regional Healthcare, INC)
- The state should be an Active Purchaser and ensure that only high quality plans can participate in the Exchange. Kentucky should use its clout as the provider so such a large consumer pool by requiring plans to compete to be part of the Exchange. (Kentucky Equal Justice Center)
- KVH believes that Exchanges should take bids from health plans to participate in the Exchange and negotiate with them to achieve the lowest possible premium rates for the highest quality of care. There should be an adequate number of plans allowed to participate in the Exchange to promote consumer choice and competition among plans. (Kentucky Voices for Health)
- Ideally, Exchanges should enhance competition, promote ongoing innovation, and increase consumer choice. To best achieve these goals, we believe that all qualified health plans should be permitted to voluntarily participate in the Exchange through an open market facilitator model. (United Health Group)
- KAM opposes mandates and additional regulatory burdens as they tend to increase costs. (Kentucky Association of Manufacturers)
- Any health care provider licensed to operate in the state should be required to provide at least one health care plan in the Exchange. (Kentucky Farm Bureau Mutual Insurance Company)
- In order to provide equal access to affordable care, all health plans should be required to participate in the Exchange and comply with the requirements. (Dr. Beth Partin DNP, APRN)
- Health plans should not be required to participate on an Exchange and each plan should have the economic choice to offer products either inside or outside the Exchange. As long as a plan meets the minimum Exchange requirements, it should be allowed to participate. The role of the Exchange is to make the product offerings available to the purchasers in an orderly and consistent manner, facilitating rather than filtering consumer driven choices. For this reason, we encourage the state to adopt a market model closer to the Utah experience rather than the regulated model of Massachusetts. (Delta Dental of Kentucky)
- An Exchange should supplement, not supplant, the insurance markets that already exist and provide coverage to many Kentuckians. The state should encourage greater choice

and diversity in plan options both inside and outside an Exchange. Health plans should voluntarily compete within the Exchange to increase choices and drive down costs. (KY Chamber)

- All health plans should be required to participate in the Exchange. This will ensure competition as opposed to plans bidding to participate. Once a plan is awarded to the bidder, the plan is autonomous and a monopoly is created. (KAC)
- Carrier participation in the Exchange should be voluntary since some carriers may not be willing or able to underwrite the risk involved in the Exchange. Any licensed carrier that meets the Exchange criteria for benefits and services should be allowed to participate in the Exchange. (Bluegrass Family Health)
- As long as a health plan/insurance carrier meets the PPACA requirements described in #1 (above) they should have the option of participating. However they should not be required. The Exchange should not act as a negotiator or have a bidding process for participation in the Exchange. The Exchange should not be able to negotiate price concessions or manipulate market pricing that would result in cost shifting. Free market competition should drive the most competitive offering within and outside of the Exchange. (Norton Healthcare)
- As a new, competitive health insurance marketplace that will give consumers more control, quality choices and better protections when they buy insurance, Exchanges should not be required to accept all plans that wish to participate. (AARP)
- In order to maximize choice, competition and health plan participation and to minimize regulatory duplication, confusion and market disruption, Anthem believes that all carriers with plans that meet the qualified health plan (QHP) standards required by the ACA and later promulgated by the Secretary should be permitted, but not required, to offer such plans in an Exchange. As such, Anthem supports a “facilitator” Exchange model. Anthem also opposes Exchanges engaging in selective contracting or bidding. (Anthem)

### **3. Should the number of benefit plans offered in an Exchange be limited or unlimited?**

- The state Exchanges should consider any Plan operating and licensed in their state today which is in good standing as a QHBP for participation in the Exchange. (CIGNA)
- The number of options should be robust, it may be prudent to institute some limit so employers and employees are not inundated with plans to the point where ascertaining the differences between them is impracticable. (KY Chamber)
- The number of benefit plans should be unlimited, allowing all that meet the minimum requirements to participate. (KAC)
- In order to maximize choice, competition and health plan participation and to minimize regulatory duplication, confusion and market disruption, Anthem believes that all carriers with plans that meet the qualified health plan (QHP) standards required by the ACA and later promulgated by the Secretary should be permitted to offer such plans in an Exchange. (Anthem)
- Initially, the number of benefit plans offer in an Exchange should be limited to ten plans per provider. (Kentucky Farm Bureau Mutual Insurance Company)
- Benefit plans offered in the Exchange should be limited. (Bluegrass Regional Healthcare, INC)

- The number of plans should be unlimited with the option to establish limits if necessary. The Cabinet should leave open the possibility of limiting the number of health plans if consumers are overwhelmed and have difficulty. (Kentucky Equal Justice Center)
- Participating health plans should be encouraged to differentiate their plan offerings to appeal to a wide variety of consumers with different needs and preferences, while remaining consistent with federal standards regarding specified actuarial values. Efforts to simplify the buying process on the Exchange are best addressed through advanced filtering and search technology to help consumers narrow the number of insurance products to those that best meet the particular needs of each consumer. (United Health Group)
- There should be no limit on the number of plans offered in the Exchange. (Dr. Beth Partin DNP, APRN)
- The number of benefit plans offered in the Exchange should be limited and standardized similar to the way Medicare Supplemental Plans are offered. This allows individuals to more easily comparison shop between carriers. (Bluegrass Family Health)
- No comment at this time. (Norton Healthcare)
- The number of plans and choices should not be limited as long as every plan offered meets the minimum requirements for participation. (Delta Dental of Kentucky)
- There should be a limit to the number of plans available to ensure consumers and employers are able to see value for premium dollars spent. Limited participation will reinforce several policy imperatives. (AARP)

#### **Market Rules:**

##### **1. Should all requirements/rules in the areas of marketing and network adequacy etc, apply to plans sold inside and outside of an Exchange?**

- The same market rules should exist for plans sold inside and outside of an Exchange. Otherwise, the risk for adverse selection is great, as Kentucky experienced with the health care reform in the mid-1990's. A level playing field is essential to the success of an Exchange. (KY Chamber)
- The Kentucky Optometric Association feels that it is critical that the consumer protections and provider fairness laws like Any Willing Provider that are currently in effect in Kentucky be maintained in any health benefit Exchange developed. Any health plans that participate in the Exchange should be subject to the current requirements of 304.17A. (KOA)
- No. Anything that might cause an insurer to leave the state should be avoided. (Kentucky Association of Health Underwriters)
- To the extent possible, market rules should be the same for insurers outside the Exchange as for those participating in the Exchange. Identical market rules for plans inside and outside Exchanges can minimize the risk of adverse selection. (Kentucky Voices for Health)
- Yes. While there are protections included in the federal law to help mitigate adverse selection in the Exchange, it is important for market rules to be the same inside and outside of the Exchange to further prevent adverse selection. (Anthem)
- The same rules should exist inside and outside of the Exchange to protect against adverse selection. (Kentucky Equal Justice Center)

- Requiring that all the same rules apply to plans sold inside and outside the Exchange or requiring that the same plans be sold inside and outside the Exchange without exception would likely serve to reduce consumer choice and competition. (United Health Group)
- Yes, Kentucky should set the same rules for insurance offered inside and outside the Exchange to prevent unfair competition and discourage cherry picking. (AARP)
- Any network, benefits or marketing arrangements a carrier offers in the Exchange should also be offered outside the Exchange, if the carrier offers any coverage outside the Exchange. (Bluegrass Family Health)
- A level playing field of the regulatory system should increase competition, which hopefully will decrease costs and make the marketplace more efficient. (Kentucky Association of Manufacturers)
- The same network adequacy standards and other rules should apply to plans sold both inside and outside the Exchange. KHA feels it is important for the state to actively monitor the marketing of plans sold in and outside the Exchange, since marketing could result in adverse selection. It is also important to assure that consumers understand any limitations that might exist with more restrictive provider networks that might exist with plans sold inside the Exchange, particularly if plans in the Exchange have different benefits and lower provider payment rates. (KHA)
- Yes, the Exchange should look and feel the same as the outside market to the extent possible thus having the same rules. Other considerations: who will negotiate between payor, Exchange and provider?; how will this process work?; if a waiver is needed, who approves, state or federal government? (Norton Healthcare)
- NO (Bluegrass Regional Healthcare, INC)
- If plans are permitted to operate outside the Exchange, the same rules should apply to plans inside and outside the Exchange. (Dr. Beth Partin DNP, APRN)
- Creating and maintaining a level playing field across on and off Exchange marketplaces will enable carriers to compete and win on fundamentals rather than tactics to game the system. Elements of a level playing field include: (CIGNA)
  - Benefit mandates that apply to all plans (including CO-OP and multi-state plans)
  - Risk pooling, risk adjustment, risk corridors, etc.
  - Ability to offer qualified plans both on and off the Exchange
  - Ability to offer multiple plan options at chosen qualified category levels
  - Ability to offer additional benefits, programs, features and services above/beyond the essential benefits
  - Annual open enrollment periods
  - Maintaining the ability to directly market to target individuals
  - Ability for brokers/agents to sell plans offered on the Exchange

## 2. Should health plans be required to offer the same product plans inside and outside of an Exchange?

- No, supplemental plans should be available in the Exchange as well to provide value added benefits and single shopping/purchase experience to “in Exchange buyers”. Exchanges should not impose standardization or cost sharing requirements beyond those federally required nor limit the number of plans a carrier can offer per plan

category to ensure a variety of plans are available to meet differing consumer needs. (CIGNA)

- Yes, the same product plans should be available inside or outside of the Exchange. (Kentucky Farm Bureau Mutual Insurance Company)
- We do not think the state or federal government should kill the innovation of the private market. Insurance companies are counting on their innovation to allow them to remain competitive. (Kentucky Association of Health Underwriters)
- It is essential to develop a standardized format for displaying plan options to consumers. Determining eligibility for Exchange participation, individual tax credits, and Medicaid/KCHIP should be streamlined using a single portal. Standardization will also discourage plans being offered outside of Exchanges that attract younger, healthier individuals- leading to adverse selection within the Exchange. (Kentucky Voices for Health)
- No. While outside of the Exchange plans must still meet the requirements of the ACA, they should otherwise be able to offer any combination of the different plan levels available within the Exchange (bronze, silver, gold and platinum) that they choose, or not offer coverage outside of the Exchange at all. Also, products sold off the Exchange would not have to be "Qualified Health Plans" and could vary in factors such as cost-sharing, out of area coverage, etc. (Anthem)
- The Exchange should not require all health plans to offer the same plans inside and outside the Exchange but should require the same tiers to be offered. Requiring health insurers to offer the same plans inside and outside of the Exchange would provide a corresponding safeguard against adverse selection. (Kentucky Equal Justice Center)
- KMA opposes mandates and additional regulatory burdens as they tend to increase costs. (Kentucky Association of Manufacturers)
- Yes, Kentucky should set the same rules for insurance offered inside and outside the Exchange. (AARP)
- Yes, to the extent that any coverage offered in the Exchange should be offered outside the Exchange. However, carriers should have the option to offer additional benefit options outside the Exchange that are not offered in the Exchange, especially if the offerings in the Exchange are controlled or limited. (Bluegrass Family Health)
- No comment at this time. (Norton Healthcare)
- KHA suggest that the same level of plans (bronze, silver, gold, etc) be made available both inside and outside of the Exchange to prevent adverse selection. (KHA)
- No. (Bluegrass Regional Healthcare, INC)
- Regarding plan design requirements, we believe that Exchanges should promote innovation and increase consumer choice. If a state does impose any design restrictions on Exchange plans, these same limits should not apply in the outside market. (United Health Group)

#### **Risk Sharing:**

1. **States are required to establish a reinsurance program for individual health plans sold inside and outside an Exchange between 2014 and 2016. The program is to be funded by fully-insured and self-insured plans. Identify what issues should be considered in establishing a temporary reinsurance program?**

- The temporary reinsurance program should be constructed in such a way that it appropriately identifies and captures all high risk individuals and seeks to align reinsurance payments with the underlying risk. Any reinsurance program should also ensure that carriers continue to have incentive to control costs and manage quality of care for these individuals. (CIGNA)
- This should be addressed by underwriters and actuaries. (Kentucky Association of Health Underwriters)
- One primary issue for consideration is the relationship of any reinsurance program with the risk adjustment programs/mechanisms that are established. Kentucky should ensure the two programs coordinate so as to avoid any double-counting that could occur if reinsurance programs were established independent of risk adjustment programs. Additionally, consideration should be given to how the state would handle the event that the need for funds is greater than one year than the amount that is available under the ACA. (Anthem)
- The primary consideration for all risk sharing activities, such as risk adjustment, risk pools and reinsurance, should be to minimize the impact on consumers. Limits should be placed on the ability of insurers to pass on reinsurance costs and risk adjustment/risk pool assessments to consumers in the form of higher premium rates. (Kentucky Voices for Health)
- The goal should be for plans in the Exchange to actually have the incentive to cover and improve care for those individuals with high needs, rather than avoid covering them in the first place. On the development of a transitional reinsurance program applicable across the market segments, including the self-insured, we urge that this process be open to extensive consumer involvement. The focus must be on assuring fair financing for the consumer with high health care needs. (AARP)
- There must be an agreement on a list of medical conditions identified as high risk. There must be a decision regarding how assessment is determined. Since assessment applies to both fully insured and self-funded business it makes more sense to calculate on a per employee or per member basis as opposed to a percent of premium or premium equivalent. Reinsurance reimbursements would be made to those carriers in the individual market that make claims payments for a member greater than a specified minimum threshold or trigger amount for each high risk condition. These minimum thresholds and scheduled reimbursement amounts need to be developed. This information then needs to be used to develop the appropriate reinsurance assessment rate to be charge. (Bluegrass Family Health)
- It is important to agree upon and use consistent actuarial assumptions and provide incentives for wellness initiatives so healthy individuals maintain a small portion. (Norton Healthcare)
- We believe it is important that the reinsurance, risk adjustment, and risk corridor processes are defined well in advance of the date that Exchanges become operational. We recommend consistency with national standards and actuarial principles, and the reinsurance approach should not remove the incentive to continue managing care for high-cost cases. (United Health Group)

**2. A risk adjustment mechanism is required to be established for health plans sold inside and outside an Exchange to adjust for unequal distribution of actuarial risk. What issues should be considered in establishing a risk adjustment mechanism?**

- Risk adjustment is designed in PPACA to address adverse selection between individuals and small group non-grandfathered plans outside of the Exchange market and cannot address adverse selection against a market including an Exchange. (CIGNA)
- Key questions in design will be 1) what level of data is required to ensure an accurate risk adjustor, 2) what entities supply this data and who collects this data, 3) how is this data then transmitted between the health plan and the entity managing the risk adjustment process. (CIGNA)
- Conscientious enforcement is necessary for the risk adjustment mechanism. (Kentucky Equal Justice Center)
- This should be addressed by underwriters and actuaries. (Kentucky Association of Health Underwriters)
- Anthem supports the development of a standard, federal methodology for risk adjustment that is concurrent and based on a diagnosis rather than a dollar threshold. Having a federal standard will promote consistency across states and Exchanges and minimize the administrative burden associated with implementing risk adjustment programs. (Anthem)
- We believe that the framework for a risk adjustment methodology for Exchanges should be established at the national level to ensure uniform standards and promote efficiency and consistency. The American Academy of Actuaries should be consulted for its recommendations on federal standards for risk adjustment, reinsurance, and risk corridor mechanisms. (United Health Group)
- Adjust for risk between two large groups of enrollees rather than attempting to perfectly predict medical expenses for individual enrollees. (CIGNA)
- The only issue that will be important to employers will be the bottom line cost of coverage. If it is more expensive than what we currently have, there will be little enthusiasm. Risk adjustment must not punish the young, healthy enrollees. (National Federation of Independent Business/Kentucky)
- How to determine an initial risk score must be decided for each individual in the Exchange. This can include basic demographic information, questionnaires or available claims information from the current carrier. This is then evaluated by the predictive modeling software package to come up with an aggregate score for each carrier separately for the small group market and the individual market. The decision has to be made as to how often an aggregate score for a carrier is updated as members elect to move between carriers. Also, there is a need to determine how individual scores are updated as Prescription Drugs and medical claims information becomes available and how this is incorporated into a carrier's overall aggregate score. Furthermore, a need to determine if charges and disbursements are done on a prospective basis, retrospective basis or both. Risk sharing needs to be separate for small group pool vs. individual pool. Reimbursements in the individual market need to reflect payments related to high risk conditions under the reinsurance program. (Bluegrass Family Health)
- No comment at this time. (Norton Healthcare)
- Limits should be in place to prevent insurance companies from passing on reinsurance rates and risk adjustments to consumers in the form of premium increases. Exchanges should be strictly regulated and should institute identical requirements for insurers inside and outside the Exchange in order to assure that the Exchange does not become a high risk pool through adverse selection. (Dr. Beth Partin DNP, APRN)

**3. For a health plan's business inside and outside an Exchange, PPACA establishes a single risk pool for small employer plans and a single risk pool for individual market plans as a way to mitigate adverse selection between an Exchange and the outside market. What issues should be considered regarding how risk pooling works between an Exchange and the outside market?**

- While the overall administration can be accomplished under one Exchange, the actual processes and risk pools should remain separate. There are unique administrative, service and insurance needs represented by both the individual and small group markets that can only be accommodated through separate processes and risk pools. (CIGNA)
- If a carrier doing business both in the Exchange and outside the Exchange has to use the same rates and rating structures for the same benefits, no additional risk pooling should be required. (Bluegrass Family Health)
- As we previously stated, allowing the subsidy to follow the individual would allow for the least amount of instability for both the Exchange, consumer (Kentucky Association of Health Underwriters)
- We feel it is important that insurance plans should have to offer "plans" in each level and risk should be pooled across all of them. (Norton Healthcare)
- A critical aspect to avoid is the destruction of the current Employers Organized Association Health Plans. These existing plans are the best path for allowing employers to band together for cost containment and group purchasing. (National Federation of Independent Business/Kentucky)
- The requirements of risk adjustment, and the temporary reinsurance and risk corridor programs, as well as the requirement that plans pool risk inside and outside the Exchanges, are critical tools to limit adverse selection and encourage plans to participate in the Exchange. However, these tools will not be sufficient if states do not apply the same rules to plans inside and outside the Exchange. (AARP)
- See response regarding risk adjustment. Additionally, it is important to understand that risk pooling is critical to mitigate risk for adverse selection that would be present if carriers could develop different rates on and off the Exchange. (Anthem)

**4. States have been given the flexibility to merge the individual market and small employer group for rating and risk sharing. What issues should be considered regarding this option?**

- We recommend maintaining separate risk pools to ensure carriers who choose to play in only of the two segments are not rewarded or penalized as a result. (CIGNA)
- A single Exchange could include both individual and small group pools that are kept separately. (KY Chamber)
- The process of simplifying the operations of the Exchange would be enhanced by administering individual and group markets jointly. A merged risk pool would spread risk over a larger and more homogenous universe and this would be more desirable than creating smaller segmented risk pools. (KAC)
- In the aftermath of HB 250, any dramatic market changes that are not mandated should be avoided at all costs. Go slowly. Watch the effects of changes in other

states before attempting changes. (National Federation of Independent Business/Kentucky)

- These are two completely distinct risk pools and the effects of merging the two pools would be detrimental to the group market. (Kentucky Association of Health Underwriters)
- Anthem believes it is important that Kentucky maintain separate distinct markets for individuals and small groups, regardless of whether or not it may consolidate the administrative functions of the individual and small group Exchanges to gain efficiencies. Combining of the risk pools for individual and small group markets is likely to lead to higher rates for small groups due to adverse selection. Maintaining separate markets will also allow insurers to tailor benefit designs to meet the needs of each market, and thus better serve individuals and small employers. (Anthem)
- If combining these markets would increase costs, then KAM would prefer they be kept separate. (Kentucky Association of Manufacturers)
- Since many of the carriers currently operate only in the group market or only in the individual market, merging the individual and small group markets would add an additional dimension of risk that these carriers may not want or be able to assume. (Bluegrass Family Health)
- No comment at this time. (Norton Healthcare)
- The state should merge the individual and small business Exchanges to create a larger pool. If Kentucky does not do this, it may find that the Exchanges lack the necessary volume to attract a sufficient number of insurers, ensure a large enough pool of enrollees that is well-balanced between the healthy and sick, and achieve the economies of scale that can keep the Exchange's administrative costs low. (Kentucky Equal Justice Center)
- We believe that maintaining separate individual and small group Exchanges and markets for rating purposes is important. States may wish to share Exchange information technology infrastructure for the individual and small group Exchanges to achieve administrative efficiencies, but the Exchanges and markets should remain separate. (United Health Group)

#### **Financing:**

- 1. A minimum essential benefit plan is required to be sold inside and outside an Exchange. A state may choose to require additional benefits but must cover the cost of the additional benefits for individuals eligible for premium subsidies through an Exchange. What issues should be considered regarding state requirements for additional benefits above the minimum essential benefit set?**

- Kentucky will have to weigh the criticality of adding any additional benefits requirements mandated through the legislation while balancing the needs of the population and the cost of coverage. (CIGNA)
- Minimum essential benefits should be available on both a subsidized and non-subsidized basis. Additional benefit options beyond the minimum essential benefits should only be available on a non-subsidized basis. Also, there might be a need to make an exception on benefit plan to match Medicaid to minimize disruption as individuals migrate between Medicaid eligibility and subsidized Exchange eligibility. (Bluegrass Family Health)

- KHA does not support the state requiring additional benefits to be added to the minimum essential benefit plan sold to individuals eligible for premium subsidies as the cost of these benefits must be covered by the state. (KHA)
- Exchanges should offer a range of health plans that are tiered according to premium and benefit levels. Consumers should have a wide range of choices depending on their circumstances. Enrollees should have access to not only physical health services but also behavioral, dental and vision services that adhere to nationally accepted guidelines. (Kentucky Voices for Health)
- KAM opposes additional mandated benefits, taxes, or fees that would lead to increased costs to the program or to employers. (Kentucky Association of Manufacturers)
- KAHU firmly believes additional benefits should not be offered, eliminating the need for funding of extra benefits. (Kentucky Association of Health Underwriters)
- Anthem opposes the imposition of additional requirements on qualified health plans within Exchanges beyond those required by the ACA. (Anthem)
- Exchanges need to be efficient and frugal in their operation. Since Exchanges must be self-sufficient by 2015, KY should consider creating an equitable system for funding. Since KY has a high risk pool and if it is funded through tax revenue or assessments, those funds could be reallocated to Exchange operations since the Exchange will make the pool obsolete. (AARP)

## **2. What funding sources should be considered for the cost of additional benefits?**

- Any benefit offerings above the minimum required should be at the expense of the individual purchasing the “richer” benefit plan. (CIGNA)
- If possible, any additional benefits to match Medicaid should be funded from the state Medicaid funding pool. (Bluegrass Family Health)
- Given the state’s financial situation, we do not believe the state can afford to pay for added benefits to persons who are already receiving taxpayer funded subsidized insurance. (KHA)
- Exchanges should consider a variety of revenue sources to fund administrative costs, including an assessment on all insurers in the market. Efforts should be undertaken to keep administrative costs in Exchanges as low as possible. (Kentucky Voices for Health)

### **Consumer Outreach and Education:**

#### **1. What types of outreach strategies are likely to be most successful for an Exchange in enrolling individuals who are eligible for premium subsidies and cost-sharing reductions, and retaining these individual in an Exchange?**

- Kentucky should consider a variety of alternative sources for distribution of key materials. Vehicles should include but not limited to advertising on television, radio, in local newspapers, town hall meetings as well as mobile media. Also, provide key information, pertinent dates relative to legislation, enrollment dates and plan offerings.( CIGNA)
- KHA suggests that the Exchange develop strong collaborative relationships with all of the state’s hospitals to enroll individuals in the Exchange who are eligible for

Medicaid or premium subsidies. By partnering with the Exchange, hospitals should be able to refer uninsured patients to the Exchange and have the Exchange perform the function of referring the patient to Medicaid to see if they qualify and assist the patient with any paperwork needed to obtain Medicaid coverage. These costs should no longer be borne by hospitals but instead should be performed by the Exchange, whose job it is to assist consumers in not only choosing a plan, but determining if they qualify for Medicaid or premium subsidies. (KHA)

- Exchanges should have an accessible, consumer-friendly website that serves as a resource for consumer education, comparison of health coverage options, eligibility determination, and enrollments. Clear contact information should be clearly displayed on the website and all information should be accessible to individuals with low literacy, disabilities and limited English proficiency. (Kentucky Voices for Health)
- The Exchange should use a broad-based outreach strategy. Kentucky has been successful in its outreach efforts to increase KCHIP enrollment. The state should consider creating a website on which individuals can apply for both health coverage and an array of public benefit programs, and incorporate that within the Exchange. (Kentucky Equal Justice Center)
- Efforts in other states have included focus group findings on consumer experience with the health information exchange and how that state has responded to those findings. In sum, the focus group participants expressed a desire for a “manageable” number of plans offered by four to six carriers. Consumer preferred for information to be presented in a simple and standardized format that clearly distinguished between different benefit design options. Also, the information of greatest interest to consumers when purchasing a health insurance plan include: monthly premium cost, co-payments for doctor’s office visits, co-pays for prescription drugs, and inclusion of his/her Primary Care Physician (PCP) in the provider network covered by the plan. (AARP)
- Identify the precise universe of individuals eligible or likely to become eligible to participate in the Exchange and concentrate marketing and educational materials on that universe of individuals. (KAC)
- Information transparency and the use of agents/brokers will help employers interface with the Exchange. (Kentucky Association of Manufacturers)
- Information about the benefit plans should be presented in common language, easily understood by consumers. Options in benefit plans should be easy to compare. In addition to web based information on benefit plans and enrollment, printed material and in person contact should be available for those without internet access or for those not able to read. (Dr. Beth Partin DNP, APRN)
- Kentucky should establish a series of public “educational workshops” for the entire provider community and should cooperate with provider groups and provider “Associations” in conducting such workshops. (KAC)
- An upgraded and expanded eligibility tracking system to better identify those individuals eligible for subsidies whether Medicaid or in the Exchange will be required. Once individuals are enrolled in Medicaid or the Exchange, the Exchange administrator should take primary responsibility for keeping the individuals enrolled and following up when they drop out of Medicaid or the Exchange. (Bluegrass Family Health)

- Consumers need basic education on health insurance and coverage levels. Many individuals believe they have coverage when it amounts to nothing because the benefit levels are so poor. (Norton Healthcare)
- Anthem is still considering these issues. Ultimately, Anthem believes that information should be provided to consumers regarding cost and quality in a way that helps them make informed decisions. (Anthem)

## **2. How can these outreach efforts be coordinated with efforts for other public programs?**

- All licensed health care providers should be provided with standardized educational material for distribution to patients, as providers will be a primary source of “informed” contact with consumers. Accordingly, special efforts should be undertaken to ensure that providers are properly educated and have a reasonable voice in the establishment and operations of the Exchange. (KAC)
- Sources such as the NAIC should be tapped to make recommendations as to specific disclosures and information that should be made accessible to the public. (KAC)
- Consider using various forms of communication. Work with Diversity Councils to determine best methods to reach individuals from a diverse cultural background. (Norton Healthcare)
- Public outreach in communities could be done to help educate consumers about the benefit plans. Venues such as community centers, churches, town hall meetings and retail centers could be utilized to set up presentations to reach consumers. (Dr. Beth Partin DNP, APRN)
- Within the enrollment portal of the Exchange there should be the option to request the help of an agent in selecting and servicing their health plan at no additional cost. (Kentucky Association of Health Underwriters)
- Community health, education and outreach workers with existing relationships in diverse communities should be incorporated into Exchange outreach efforts. Outreach efforts involving partnerships with communities and public facilities should also create and utilize an Advisory group with consumer representation as a regular resource to provide input on proposals and share information. Coordination with advocacy organizations such as Kentucky Voices for Health should also be incorporated in the outreach plan. (Kentucky Voices for Health)
- Anthem is still considering these issues. Ultimately, buyers should be able to shop, compare and purchase plans on the Exchange, however, carriers should retain the ability to sell plans directly or through a broker as well. The creation of a consumer-friendly online selection tool that allows consumers to input information and efficiently find the products that are right for them will also be important. (Anthem)
- Delta Dental envisions a model that draws upon online purchasing experiences that consumers currently utilize such as Travelocity, Amazon, eBay, and Craigslist. The consumer needs to be able to compare products (benefits) and pricing in a chart format and by product attribute. (Delta Dental of Kentucky)

### **3. What kinds of design features will help consumers obtain coverage through an Exchange?**

- The Commonwealth should look to best in class websites and practices to simplify and streamline the access to critical information and decision points and offer a cost comparison tool. (CIGNA)
- Provide an easily understood portal of information for consumers, health care providers, employers, insurers, and others. (KMA)
- Exchange websites should be consumer friendly and easy for an individual to use without assistance. (KHA)
- Information should be presented clearly and succinctly and consumers should have the ability to search by keyword, product, company and other criteria to be determined by customer survey. Current medical and dental carriers utilize online purchasing tools so the technology and capability is readily available to the Exchange. (Delta Dental of Kentucky)
- Information transparency and the use of agents/brokers will help employers interface with the Exchange. (Kentucky Association of Manufacturers)
- Account for citizens who do not speak English. (Kentucky Association of Health Underwriters)
- Anthem is still considering these issues. However, it is important to note that the ACA requires the establishment of a network of Navigators to raise awareness among customers of their coverage options and to help people select and enroll in health plans and subsequently access benefits. Navigators should work in concert with brokers, and should have expertise in reaching hard-to-reach populations. (Anthem)
- The Exchange should maintain a comprehensive website, which includes cost and coverage, and a toll-free hotline. Also, offer different languages with detailed information on all benefit plans including providers, breadth of coverage, and applicable deductibles and co-insurance. (Kentucky Equal Justice Center)

### **4. What information are consumers likely to find useful from Exchanges in making plan selections?**

- Include plan choice (benefits, costs, ancillary products, chronic conditions programs and wellness choices. (CIGNA)
- Individuals should be able to obtain summary plan information (services covered, provider network, premium costs, cost sharing) from the Exchange rather than being re-directed to each insurance company's website where it may be difficult to find the plans being sold in the Kentucky Exchange. Also, it would be helpful for the Exchange to provide web-based tutorials explaining how to use the site and also how to compare plans. It might also be helpful for the Exchange to develop a program to assist consumers in selecting the appropriate plan level by having them enter needed benefits and desired cost sharing to narrow down the plans that would best meet those criteria. (KHA)
- Consumers need basic, easily understandable information to help them decide which option will best meet their needs. This includes not only the kind of information normally seen - provider networks, the monthly costs, the co-payments for drugs and other services –but also scenarios showing what consumers can

expect to pay out-of-pocket if they have common chronic conditions or a hospital stay. Also, consumers should have access to insurer's history of paid versus denied claims, some measure of claim handling complaints and how they were resolved, and its medical loss ratio in the individual and small group market.(AARP)

- The following information should be prominently presented in a clear and concise format, using standardized terminology and descriptions, on any Exchange website and in written materials for consumers without internet access. This information must be timely, reliable and comprehensible: provider networks (and quality); benefit description; premium costs and cost-sharing; coverage level (bronze, silver, gold, platinum); plan accreditation status; information on chronic disease management; sample cost and health benefit examples; medical loss ratio; actuarial value of health plans and plan financial information (including annual profit and executive salaries). (Kentucky Voices for Health)

5. Which types of enrollment venues are likely to be most helpful in facilitating individual enrollment in Exchanges and qualified health plans?
6. What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plans to select?
  - Cost and comparison tool. (CIGNA)
7. What are some best practices in conveying information to consumers relating to health insurance, plan comparison, and eligibility for premium subsidies, eligibility for Medicaid?
8. What types of efforts should be taken to reach individuals from diverse cultural origins and those with disabilities or low literacy?
  - To reach those consumers from diverse cultural origins the availability of a language line to support consumer understanding and navigation of the website will be crucial to ensuring those individuals make informed choices. (CIGNA)